HealthCare.gov

Improving Care Transitions

Care transitions refer to movement of patients from one health care provider or setting to another. For people living with serious and complex illnesses, transitions in setting of care (from hospital to home or nursing home, for example) are prone to errors. For example, one in five patients discharged from the hospital to home experience an adverse event within three weeks of discharge, when an adverse event is defined as an injury resulting from medical management rather than the underlying disease. The most common adverse events are medication related; they often can be avoided or mitigated. The rate for hospital readmissions among Medicare beneficiaries within 30 days of discharge, one indicator of the appropriateness of the transition process, is 20%, contributing to lower patient satisfaction and rising health care costs.

Goal: The Partnership for Patients will advance efforts to decrease preventable hospital readmissions within 30 days of discharge, so that by 2013 all readmissions would be reduced by 20% compared to 2010. This would mean prevention of more than 1.6 million avoidable readmissions.

Roadmap to Better Care Transitions and Fewer Readmissions

Background on Care Transitions

We are developing a better understanding of what is needed to ensure safe and effective patient transitions from one health care setting to another. An increasing number of governmental and nongovernmental programs, training and learning opportunities, and resources are available to help providers and communities improve their ability to safely and effectively transition patients from one care setting to another. This Roadmap may help providers and communities navigate the processes of care transition and access helpful programs, learning and training opportunities, and resources. The Roadmap will be updated so check back often.

Why should providers care about care transitions?

Care transitions refer to the movement of patients from one health care provider or setting to another. For people with serious and complex illnesses, transitions in setting of care--for example from hospital to home or nursing home, or from facility to home- and community-based services--have been shown to be prone to errors.

Nearly one in five Medicare patients discharged from the hospital is readmitted within 30 days. This translates to approximately 2.6 million seniors at a cost of over $26 billion every year. Readmission rates are also high for patients covered by Medicaid and private insurance.

Medication errors, poor communication, and poor coordination between providers from the inpatient to outpatient settings, along with the rising incidence of preventable adverse events, have drawn national attention. Health care providers and community-based organizations are aware of the negative effects of poor patient care transitions. But many struggle with fragmentation and lack of collaboration across settings, limited resources, and an expanding aging population with multiple chronic conditions.

The Department of Health and Human Services is committed to promoting high quality health care and improving patient outcomes. For one example, the Affordable Care Act calls for progressive reduction in Medicare payments to hospitals beginning in fiscal year 2013 based on high rates of 30-day readmissions for Medicare beneficiaries.

The goal is to ensure that the hospital discharges are accomplished appropriately and that care transitions occur effectively and safely. The goal is not to avoid re-hospitalizations that are the best treatment option for an individual.

Who is at particular risk of poor care transitions and readmissions?

Several factors may affect the risk of unplanned, unintended readmissions. These include patient characteristics (such as demographics, socioeconomic, behaviors, and disease states); activities and events associated with the delivery of hospital care; and environmental factors. People with terminal illnesses and multiple chronic medical and mental health conditions are most prone to harm from inadequate transitions, especially if they have fragile support systems in the community. Issues with housing, transportation, formal and informal supports and services, and other basic needs further complicate care transitions.

Elements of a good care transition

Safe, effective, and efficient care transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community and in long-term care facilities.

Providers that must work together to ensure safe transitions include at least the following: hospitals, clinicians practicing in the ambulatory setting, home care agencies, community service providers, and post acute facilities (such as skilled nursing facilities, rehabilitation, and assisted living). While much of the discussion addresses the transition from acute hospital to home or other post acute setting, the principles and resources are relevant for all transitions from one health care setting to another.

Because the combination of patients' medical and social situations, preferences, and community resources could create an endless variety of care plans, quality care requires that a patient-centered plan for each patient exists and continues across time and settings. Patients and their families are the most constant element in transitions and their contribution is essential to safe and effective transitions.

Elements for safe, effective and efficient care transitions should include:

- Patient (or caregiver) training to increase activation and self-care skills. For example, see the Care Transitions Intervention℠, developed by Eric A. Coleman, MD, MPH.
- Patient-centered care plans--negotiated with patient and family and responsive to the medical and social situation and the availability of services--that are shared across settings of care.
- Standardized and accurate communication and information exchange between the transferring and receiving provider in time to allow the receiving provider to effectively care for the patient.

Examples: Continuum of Care Transfer Form, Georgia Medical Care Foundation (GMCF) (PDF) and Universal Transfer Form, American Medical Directors Association (AMDA) (PDF)
- Medication reconciliation and safe medication practices
- Ensured transportation for health care-related travel
- Procurement and timely delivery of durable medical equipment
- Ensuring the sending provider maintains responsibility for care of the patient until the receiving clinician/location confirms the transfer and assumes responsibility

Information that should be provided across care settings includes:

- Primary diagnoses and major health problems
- Care plan that includes patient goals and preferences, diagnosis and treatment plan, and community care/service plan (if applicable)
- Patient's goals of care, advance directives, and power of attorney
- Emergency plan and contact number and person
- Reconciled medication list
- Follow-up with the patient and/or caregiver within 48 hours after discharge from a setting
- Identification of, and contact information for, transferring clinician/institution
- Patient's cognitive and functional status
- Test results/pending results and planned interventions
- Follow-up appointment schedule with contact information
- Formal and informal caregiver status and contact information
- Designated community-based care provider, long-term services, and social supports as appropriate.

Establishing standard practices and building seamless connections to community-based services are important. Building and connecting the community infrastructure and establishing community standards and priorities are essential to shaping a system that will provide safe and effective transitions of residents across health care settings.

When considering the connections, interactions, and integration needed to consistently ensure safe and effective transitions, communities can be roughly sorted into three groups:

- those interested in getting started or just beginning to work together
- those that have developed some working relationships and have some experience in working together on transitions
- those moving toward more seamless, integrated models

These types of communities are eligible for different programs and require different learning opportunities and resources.

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For Providers in Communities Getting Started on Care Transitions

The Care Transitions Quality Improvement Organization Support Center (QIOSC) and Administration on Aging (AoA) web pages on the Affordable Care Act and Aging & Disability Resource Centers Evidence-Based Care Transitions Program include toolkits that provide information and tools that help guide providers and communities to develop the relationships and build the infrastructure needed to improve the safety and effectiveness of individuals transitioning from one setting to another and reduce

the occurrence of unnecessary, preventable hospital readmissions. The Center for Medicare and Medicaid Services' Community Services and Long Term Supports web pages provides information about and contacts for Medicaid programs that improve care transitions, such as the Community Living Initiative and Money Follows the Person Rebalancing Demonstration Program.

- **The QIOSC website:** Information contained within the Quality Improvement Organization (QIO) Support Center (QIOSC) toolkit resulted from experiences in the 9th Statement of Work (SOW) Care Transitions Theme, whose goal was to improve transitional care for a population of fee-for-service Medicare beneficiaries living in 14 selected communities. Success was measured by reductions in hospital readmission rates. The toolkit describes community participants, the role the local QIOs can play, strategies for community recruitment and engagement, root cause analysis, and ways to measure success.

- **The Administration on Aging Care Transitions Toolkit**: Developed for states, Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), Tribal Organizations, and other local service providers within the Aging Network, the Administration on Aging Care Transitions Toolkit is targeted to organizations interested in learning how to prepare for a future role in care transition programs. The resources describe items to think about when getting started and can assist in formalizing efforts for future funding and program opportunities. The toolkit is available on AoA's Affordable Care Act and Aging & Disability Resource Centers Evidence-Based Care Transitions Program web pages.

- **Medicaid programs** related to care transitions and community services: Find the resources located at http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp. For more information about Health Homes, download State Medicaid Director Letter (SMDL# 10-024), which provides preliminary guidance on the implementation of health homes for Enrollees with Chronic Conditions.

- **Community activities related to care transitions**: Developing effective approaches to improved care transitions requires community engagement, root cause analysis, and measurement of care transition process, outcome, and utilization. The QIOSC and AoA websites provide information on these topics:
    - Strategies for community recruitment and engagement.
    - Root cause analysis -- a process for identifying the basic or causal factors that underlie variations in outcomes, such as hospital readmissions-- allows you to identify the "root" of the problem, and suggests processes for redesign to improve outcomes.
    - Measurement of the processes and outcomes of care transitions is essential to demonstrating whether the care transition plan, actions, and interventions are effective. The Agency for Healthcare Research and Quality (AHRQ) also provides a general primer on performing root cause analysis for patient safety related problems.

Government Programs For Communities Getting Started

Several complementary public sector initiatives with a focus on improving care transitions are operating or planned. Communities and health care systems should take advantage of the programs, resources, and relevant learning opportunities appropriate to their setting and needs.

Examples of government programs appropriate for providers in communities getting started on building the relationships and infrastructure needed to improve the safety and effectiveness are listed here. These programs provide various combinations of technical assistance, financial support, and learning

opportunities. The programs are directed toward Medicare beneficiaries, Medicaid beneficiaries, or people with both Medicare and Medicaid coverage. Brief descriptions are provided with links or references for additional information.

Federal Programs

- **Quality Improvement Organization (QIO):** Information on the QIO 10th Statement of Work is available through the CMS website.
- **Your Quality Improvement Organization (QIO):** CMS contracts with one organization in most states to implement improvements in the quality of care in all settings. Your state QIO, which can be found at **http://www.cms.gov/qualityimprovementorgs**, can provide technical assistance such as convening relevant providers.
- **Administration on Aging (AoA) Aging and Disability Resource Center (ADRC) Evidence Based Care Transitions Program**: ADRCs assist individuals making decisions about long-term care. This work includes innovative interventions to facilitate the hospital discharge process and help nursing facility residents return to the community. The 2010 ADRC Evidence Based Care Transitions Program supports 16 states to strengthen the role of ADRCs in implementing evidence-based care transition interventions that engage older adults and individuals with disabilities (and their informal caregivers).

State-focused Programs

There are several programs that offer financial support for performance measurement-related activities and technical assistance for state Medicaid and CHIP agencies that want to improve the safety and effectiveness of care transitions and reduce readmissions. Examples of programs include:

State Demonstrations to Integrate Care for Dual-Eligible Individuals Design Contracts: 15 states have been selected to design new approaches to better coordinate care for dual-eligible individuals. The selected states will have up to 12 months to work with stakeholders to develop a detailed demonstration model describing how the state would structure and implement an intervention that aligns the full range of Medicare and Medicaid primary care, acute care, behavioral health, and long-term supports and services. Care transitions work is likely to be an important element of such programs.

States that successfully complete their design contract may be eligible to receive support to implement their demonstration models, pending federal approval and funding availability. Providers interested in working with these states should get in touch with the state contacts identified on the CMS website.

Who is participating: The states of California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington and Wisconsin were selected to receive design contracts as part of this effort.

Resources and technical assistance provided: CMS will provide funding and technical assistance to the selected states to develop person-centered approaches to coordinate care across primary, acute, behavioral health, and long-term supports and services for dual-eligible individuals. CMS is also making technical assistance available to all states interested in improving services for dual-eligible individuals.

Time of start and duration of the program design period: April 2011-April 2012; implementation will occur in 2012 and beyond.

Medicaid Community Services and Long Term Supports/ Medicaid Grant Programs: CMS is

working in partnership with states, consumers and advocates, providers, and other stakeholders to create a sustainable, person-driven long-term support system in which people with disabilities and chronic conditions have choice, control, and access to a full array of quality services that assure optimal outcomes, such as independence, health, and quality of life.

Resources and technical assistance

Time and Duration of Program: See individual programs for details.

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Government Programs for Communities with Experience Working Together

Several complementary public sector initiatives with a focus on improving care transitions are operating or planned. Communities and health care systems should take advantage of the programs, resources, and relevant learning opportunities appropriate to their setting and needs.

If you are a provider in a community where providers from different settings--such as hospitals, primary care, post-acute facilities, and community-based organizations--have already developed working relationships and have some experience in working together on transitions, there are programs available to help move toward even better integration across care settings. These programs provide various combinations of technical assistance, financial support, and learning opportunities. The programs are directed toward Medicare beneficiaries, Medicaid beneficiaries, or people who have both Medicare and Medicaid. Brief descriptions are provided with links or references for additional information.

Federal Programs

Community-Based Care Transitions Program (CCTP), Affordable Care Act Section 3026: Tests models for improving care transitions from hospital to other settings and reducing readmissions for high risk Medicare beneficiaries. Community-based organizations (CBOs) will use care transition services to effectively manage transitions and report process and outcome measures on their results.

- **Who is eligible:** In selecting CBOs, preference will be given to AoA grantees that provide care transition interventions in conjunction with multiple hospitals and practitioners and/or entities that provide services to medically underserved populations and across a continuum of care. Consideration will be given to organizations that have established care transition interventions with state Medicaid programs and organizations that have established relationships with medical homes serving Medicare beneficiaries. Consideration will be given to hospitals whose 30-day readmission rate on at least two hospital compare measures falls in the top quartile for its state. Eligible CBOs' governing bodies must include sufficient representation of multiple health care stakeholders, including consumers.
- **Resources and technical assistance provided:** The CBOs will be paid an all-inclusive rate per eligible discharge based on the cost of care transition services provided at the patient level and of implementing systemic changes at the hospital level. Program participants will form a learning network.
- **Time of start and duration of the program** Rolling applications were accepted beginning April 12, 2011, and continue as funding permits.

Medical Homes and Accountable Care Organizations: The primary care and patient-centered medical home is a promising model for transforming the organization and delivery of primary care. Key

features of medical homes include team-based care, a robust care coordination and care management capacity, patient-centered care with strong support for self-management of health, an emphasis on access and relationships, the use of clinical data to proactively plan care and manage populations, and a systems-based approach to quality and safety. Accountable Care Organizations (ACOs) are groups of health care providers who accept joint responsibility for the cost and quality of care outcomes for a specified population of patients. They provide organizational infrastructure and the relationships that weave together the team of providers in order to improve coordination of care. In March 2011, CMS issued a proposed rule in which it outlined its policies for implementing the Medicare Shared Savings program under which ACOs may coordinate care for assigned Medicare fee-for-service beneficiaries. In addition, the Innovation Center has announced several ACO initiatives. Creating the relationships and infrastructure across providers and care settings and instituting evidence-based care transition and readmission reduction programs will be essential to successful Medical Homes and ACOs.

Opportunities for Medical Homes and ACOs are coming. Check the Center for Medicare and Medicaid Innovation website for updates.

State-focused Programs

Health Homes coordinate primary, acute, behavioral health, and long-term care services and supports using designated health home providers. Services include: care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support; referral to community and social support services, if relevant; and use of health information technology to link services, as feasible and appropriate.

- **Who is eligible:** Medicaid eligible individuals with chronic conditions who select a designated health home provider. Eligibility is described in the November 2010 letter to State Medicaid Directors and Health Officials.
- **Resources or technical assistance provided:** CMS is providing technical assistance to states interested in submitting a State Plan amendment. A Health Home email address -- healthhomes@cms.hhs.gov-- is available for questions or requests for technical assistance.
- **Time of start and duration of the program:** States can submit a Medicaid State Plan option as of January 1, 2011.

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Learning Opportunities

Several Health and Human Services (HHS) agencies offer training and learning opportunities including regional events, conferences, learning collaboratives, conferences, webinars, and PowerPoint presentations to help providers (such as hospitals, post-acute facilities, clinicians and CBOs) learn how to improve the safety and effectiveness of care transitions. Three examples are listed here. Check back regularly as these are updated. Links to archived materials are also provided.

- **Quality Improvement Organization Care Transitions Learning Sessions**. Quality Improvement Organizations (QIOs) participating in the CMS-supported Care Transitions theme are working with community providers to improve the quality of care for Medicare beneficiaries living in 14 targeted geographic areas. These communities have implemented a variety of evidence-based interventions directed towards improving care transitions. In learning sessions, participating providers and QIOs discuss best practices and lessons learned in care transitions.
- **Administration on Aging (AoA) offers monthly webinars focused on the Affordable Care**

Act and its impact on the Aging Network. This initial series of webinars focuses on preparing the Aging Network to participate in the Community-based Care Transition Program demonstration (Sec. 3026 of the Affordable Care Act).

- **Person-Centered Hospital Discharge Model:** Provides targeted assistance to states to support efforts to improve hospital discharge planning through collaboration with Aging and Disability Resource Centers (ADRCs), Area Agencies on Aging (AAAs), and Centers for Independent Living (CILs).

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