# CHAPTER 3

# TRANSITIONS OF CARE AND POST-ACUTE CARE SERVICES

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## Learning Objectives

*After completing this chapter, you should be able to*

- discuss *transitions of care* between acute care, residential long-term care, and home and community-based long-term care settings within the United States healthcare delivery system;
- define *care coordination services* and discuss their importance in transitions of care;
- discuss subacute and post-acute care and their roles in transitions of care;
- understand the impact of key healthcare policies and regulations on transitions of care;
- understand the role of technology and health information systems in the coordination of care during transitions; and
- examine future directions for transitions of care in healthcare delivery systems.

## Introduction

In the years since the passage of the Affordable Care Act, increasing attention has been paid to the transitions of individuals across the various levels and sites of healthcare services. Traditional approaches to the discharge from acute care settings to rehabilitative healthcare services have often resulted in adverse events such as the worsening of symptoms, errors in medication, and problems accessing follow-up care and testing. The Centers for Medicare & Medicaid Services now apply financial penalties to acute care settings for hospital readmissions within 30 days of discharge—a practice that underscores the growing focus on care transitions following medical procedures. However, the reality is that much remains to be learned about how to transition an individual through care settings, and about the types of interventions and supportive transition services that can improve outcomes of care and quality of life for individuals and their families.

This chapter explains what is meant by *transitions of care* and the related term *care coordination*. It will examine several key issues, including the types of care transitions, the role of post-acute care services in transitions of care, legislation affecting care transitions, and the development of new interventions. The chapter also provides an evaluation of transition services related to health outcomes and a look at innovative initiatives and future directions in care transitions.

## Transitions of Care and Care Coordination

Transitions of care involve efforts to ensure coordination and continuity while moving individuals from one setting of healthcare services to another (Naylor and Keating 2008). These transitions may be assisted by various types of providers that guide individuals and their caregivers through the process of receiving healthcare services or recovering from medical procedures.

***care coordination***
The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of healthcare services.

**Care coordination** is an essential part of the transitions of care process. It involves planning, organizing activities, and sharing information across two or more providers of healthcare services to ensure safer and more effective care. Effective care coordination ensures that individuals' needs and preferences are known in advance and communicated at the right time to the right people, so that the information can be used to provide safe, appropriate, and effective care. (Much of the information can be exchanged through electronic health record systems.) Typically, care coordination involves sharing information about the individual's preferences, treatment goals, and health status; addressing logistical arrangements; and providing education for the individual's caregivers, family, and loved ones (National Transitions of Care Coalition Measures Work Group 2008).

Transitions of care can apply to any individual regardless of age, health status, or disability. However, individuals most affected by these transitions are older adults and individuals with multiple chronic health conditions. Transitions of care have become

an increasingly important issue since the Affordable Care Act instituted penalties in the Medicare system for readmission of individuals to hospitals within 30 days of discharge.

## Healthcare Providers and Transitions of Care

A variety of healthcare providers are involved in transitions of care. They include acute care providers, such as hospitals; ambulatory care services; home and community-based service providers; and long-term care or rehabilitation services. Each type of provider plays an important role in facilitating care transitions through the healthcare delivery system.

### Acute Care Providers: Hospitals and Healthcare Systems

Because hospitals are usually the acute care setting where patient treatment begins, they play a major role in transitions of care. For example, when an individual is admitted to a hospital for a procedure, the hospital initiates a discharge planning process that includes transitions to the patient's home or to another setting, such as a long-term provider of rehabilitation services.

Additionally, hospitals may offer specialized services within the facility for older adults or individuals with chronic conditions, with the aim of enhancing care coordination while patients are in an inpatient setting. Such services may include specialized emergency department units for older adults—with soundproofed rooms, thicker mattresses to prevent bedsores, and flooring without glare to prevent falls—as well as follow-up calls to discharged patients in the first week after returning to their homes. Although, thus far, relatively few healthcare systems have implemented specialized units of this type, preliminary studies show significant declines in hospital readmissions for patients using the services (Grudzen et al. 2015).

***Acute Care for Elders (ACE) Unit***
An inpatient unit specializing in care for adults aged 65 or older with an acute medical condition requiring hospitalization. Individuals at risk for delirium, dementia, depression, incontinence, or falls, or those requiring large numbers of prescription drugs, are candidates for admission.

**Acute Care for Elders (ACE) units**, another relatively new form of inpatient care, specialize in geriatric care to reduce the risk of functional decline of a hospitalized older adult. Patient rooms typically include beds that can be lowered for easier access, raised toilet seats, and enhanced lighting. Care protocols may specify patient hydration, and blood draws and overnight interruptions may be kept to a minimum to encourage individuals to be as active as possible. An interdisciplinary team with specialized geriatric care training typically provides care in ACE units while also helping facilitate individuals' discharge back to the community or to another care setting. Studies of ACE units for older individuals have shown decreased incidence of falls, lower costs of hospital stays, and reduced 30-day hospital readmissions (Flood 2013).

Some hospitals have initiated early palliative care consultations to identify patients who may be need hospice or other end-of-life care services. The consultations may encourage healthcare providers to discuss such services with patients and family members, and they may lead to reduced hospital readmissions and higher quality of life for patients. A

study of early palliative care interventions for patients with metastatic non-small-cell lung cancer found that the interventions led to significant improvements in patients' quality of life and mood, as well as longer survival and less aggressive care at the end of life (Temel et al. 2010). An additional study of patients in a California hospital further demonstrated the effectiveness of inpatient palliative care consultations. When an interdisciplinary consultation team was used, readmissions to the hospital six months after consultation decreased from 1.15 to 0.7 admissions per patient, with a potential cost savings between $63,994 and $251,053 per 100 patients who had consultations (Nelson et al. 2011).

Hospitals may use **subacute care** services for individuals who need more intensive rehabilitation care. Subacute units are within an acute care setting but do not provide the intensity of care needed in an acute care bed; rather, they are appropriate for the maintenance of patients with severe chronic conditions who need specialized services and treatments. The term *subacute care* emerged in the 1980s in response to new technologies and reimbursement changes that enabled people with severe chronic conditions to be treated in settings other than acute care hospitals. Subacute patients include those who are ventilator dependent; need rehabilitation services after surgery; require rehabilitation therapy following a stroke, head injury, or spinal cord injury; or are receiving complex intravenous medication therapy such as high-dose antibiotics or chemotherapy (Griffin 1995).

***subacute care***
Maintenance of individuals with severe chronic conditions who require specialized services and treatments. Typically, subacute care is provided in an acute care setting but does not involve the intensity of hospital services.

**Discharge planning—**the process of planning and moving a patient from one care setting to another care setting or back to the community—is an important component of a transition of care. The discharge process may begin at the time an individual is admitted to a care setting such as a hospital, nursing home, or rehabilitation service provider. The process requires an assessment of the individual's needs and the identification of services, assistive technology, medications, and other supportive services to be included in the individual's transitional care plan. In addition, an interdisciplinary team of healthcare providers may be involved in the transitional care plan to ensure a safe transition to the next setting. A variety of home and community-based service providers may also participate in the discharge planning process depending on the needs of the individual being transitioned.

***discharge planning***
The process of planning the movement of an individual from one care setting to another care setting or back to the community. It typically involves the creation of a transitional care plan, as well as participation from a multidisciplinary team of providers.

With the intensified focus on reducing hospital readmissions, hospitals have created new roles for hospital-based physicians (hospitalists) specializing in long-term services. Called **SNFist physicians** (based on the acronym for skilled nursing facilities), these individuals assist the discharge planning department with facilitating patient transitions to long-term settings for post-acute services. **Post-acute care (PAC)** includes a range of medical care services that support the individual's continued recovery from illness or management of a chronic illness or disability (California Hospital Association 2016). Post-acute care may be delivered in a variety of settings, including **long-term care hospitals (LTCHs)** and **inpatient rehabilitation facilities (IRFs)**, as well as skilled nursing facilities (SNFs) and home health agencies (HHAs), which are discussed in detail in chapters 4 and 5. Individuals in PAC settings receive nursing, therapy, and rehabilitation services under the direction of physicians. Although some overlap exists, each of the PAC settings offers a different level

***SNFist physician***
A hospital-based physicians who specializes in the transition of patients from acute care settings to subacute or post-acute care settings. *SNF* stands for *skilled nursing facility*.

of care as a result of statutory requirements and payment policies (Grabowski et al. 2012; American Hospital Association 2010).

In 2013, 42 percent of Medicare beneficiaries leaving acute care hospitals used post-acute care services, with 20 percent discharged to a SNF, 17 percent discharged to an HHA, 4 percent discharged to an IRF, and 1 percent discharged to an LTCH. Medicare's payments for post-acute care services have been significant: By 2013, program payments to PAC providers totaled $59 billion (Medicare Payment Advisory Commission 2015).

An individual's functional status, complications, and comorbidities—together with nonclinical factors such as family support, home environment, and care preferences—influence the selection of a particular PAC setting. For instance, a stroke patient requiring medically complex treatment might need the hospital-level rehabilitative care typically provided by an IRF. Meanwhile, a frail older adult who has had a stroke might need to remain in a SNF, whereas a more stable stroke patient might be treated through home visits. The PAC landscape will continue to evolve as providers experiment with new delivery models (American Hospital Association 2010).

***post-acute care (PAC)***
Care delivered after a stay in an acute care hospital. Settings for such care include long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and home health agencies.

***long-term care hospital (LTCH)***
A facility that treats patients who require intensive, long-term services for complex problems, such as multisystem organ failure, or are ventilator dependent. Care at an LTCH often follows an acute-care hospitalization. Overall severity of illness for LTCH patients is greater than it is for typical post-acute care patients.

***inpatient rehabilitation facility (IRF)***
A facility licensed as a hospital or certified unit of a hospital and oriented toward rehabilitation. Patients in IRFs may require the care of specialty physicians, registered nurses, and therapists following such events as strokes or brain and spinal cord injuries.

## Home and Community-Based Settings: Providers and Services

Home and community-based service providers are also involved in the discharge planning and care transitions process. A list of home health agencies, medical equipment providers, and community service organizations may be provided to individuals needing transitional care. Usually, a discharge plan dealing with access to services is created prior to the individual's transition to another setting. Medical information about the individual—including specific instructions for medications and other types of care—will often be provided to the individual's primary care physician and caregivers within seven days of discharge. An individual with a terminal illness or condition, as certified by a hospice medical director or other medical professional, may be transitioned to end-of-life services in the community (e.g., hospice or palliative care).

The Older Americans Act and Aging Network services such as Area Agencies on Aging (AAAs) or Aging and Disability Resource Centers (ADRCs)—discussed at length in chapter 5—are required by federal statute to help connect individuals to community services and supports. These organizations may be involved in the discharge planning process to help avoid hospital readmissions. Centers for Independent Living (CILs), a grassroots network of community service providers operated by individuals with disabilities for people with disabilities, may also be involved in care transitions; they may also have funding to assist individuals with movements back to the community.

Family caregivers and loved ones may also be involved in the care transitions process. In some states, patients are asked by hospitals to identify a caregiver in the community and to grant consent to the caregiver related to their discharge schedule, as well as a list of medications for the post-transition process. Eighteen US states have **CARE laws**, which require hospital employees to involve patients' caregivers and loved ones in the hospitalization and discharge planning process.

**CASE FROM THE FIELD**
Vermont's Services and Supports at Home Program

Launched in 2011, Vermont's Support and Services at Home (SASH) program is part of a larger Medicare initiative, the Multi-Payer Advanced Primary Care Practice demonstration. SASH provides a model of care coordination services centered on affordable housing sites for older adults. It connects residents with community-based services and promotes coordination of healthcare services using on-site staff (a coordinator and wellness nurse), wellness assessments, individual plans of care, and one-on-one nurse coaching. Services also include assistance in transitions of care for program participants discharged from hospitals. An analysis using claims data from a sample of Medicare fee-for-service beneficiaries found that growth in annual total Medicare expenditures was lower, by an estimated $1,756 to $2,197 per beneficiary, among beneficiaries enrolled in well-established SASH panels than among members of comparison groups (Office of the Assistant Secretary for Planning and Evaluation 2014).

## Historical Perspectives on Care Transitions

Traditionally, the US healthcare system has focused on acute care needs, with treatment typically provided in acute care hospitals—that is, places where sick people would stay until they recovered. In contrast, nursing homes were facilities where older adults lived and received care. Post-acute care delivery evolved in response to Medicare, Medicaid, and private insurance reimbursement policies, with the aim of accommodating the acute care model of treating time-limited and specific illnesses or injuries (Wagner et al. 2001). Ultimately, the aging population and the growing prevalence of chronic disease made the acute care focus insufficient. According to Centers for Medicare & Medicaid Services Medical Expenditure Panel data from 2012, nearly 66 percent of older adults have at least two chronic conditions, and nearly one in four (23.2 percent) report receiving treatment for four or more conditions (Chevarley 2015). Though these individuals may experience acute illnesses throughout their lifetime, such episodes will be complicated by the presence of chronic conditions that must also be attended to by medical, long-term care, and support systems (Golden and Shier 2013).

***CARE laws***
State laws that require hospital employees to involve patients' caregivers and loved ones in the hospitalization and discharge planning process. CARE stands for Caregiver Advise, Record, Enable.

Changes in payment systems have had a profound influence on the transition from acute to post-acute care. The shift to prospective payments created incentives for hospitals to decrease patient length of stay. Patients no longer stay in the hospital until they are completely well; instead, they are discharged to post-acute settings such as rehabilitation hospitals, long-term care facilities, nursing homes, and skilled nursing facilities for recovery. Though acute and post-acute care play distinct roles in healthcare service transitions, collaboration

between the two is critical for smooth, efficient care management (Wolf 2003). The need for collaboration has become even greater in the wake of changes in reimbursement brought about by healthcare reform legislation.

Care provided in the acute, episodic model may not meet the needs of patients with chronic conditions. Evidence of poor clinical outcomes and unnecessary spending of Medicare and Medicaid resources has prompted new thinking related to the management of post-acute care services and care transitions. Patients with chronic conditions require continuous care and coordination across healthcare settings and providers. They often also require supportive services such as personal assistance, home health care, or help navigating the healthcare system. Such services need to be readily available and coordinated with clinical treatment for maximum effectiveness (Anderson 2010).

### Benefits of Collaboration between Acute and Post-Acute Care Settings

In a system where individuals being treated can move from an emergency room to a hospital to a rehabilitation facility and then to a nursing home, collaboration is essential for ensuring smooth transitions (Wolf 2003). Failure to coordinate information between levels of care can impede patients' recovery at home or in a post-acute facility and, in some cases, put patients in danger of losing their ability to care for themselves.

Data from a variety of studies show what providers need to do when patients transition from one level of care to another. Key tasks include managing and reconciling medications, sharing detailed information with the next level of care, and ensuring patient and family involvement (*Hospital Case Management* 2011). Studies support the use of **transition coaches**—sometimes called care navigators—to deliver transitional care services for post-acute care patients and their family and caregivers (Toles et al. 2012, 46). Transition coaching can also help reduce the number of readmissions to acute care (Gardner et al. 2014; Voss et al. 2011).

***transitions coach***
An individual who specializes in assisting patients and residents in movements through the care transitions process. Use of transition coaches—also called care navigators—has been linked to significant cost savings and improved quality outcomes.

In 1999, Dr. Eric Coleman started the Care Transitions Intervention, a Colorado-based program that uses transitions coaches to help individuals identify their goals after discharge and navigate the care transition process. The program reported reductions in hospital readmissions between 20 and 50 percent and a net savings of $365,000 per transitions coach over 12 months. Additionally, the majority (52 percent) of participating patients reported meeting or exceeding their transitions process goals (Care Transitions Program 2016). In the wake of these findings, CMS launched its Community-Based Care Transitions Program, which was included in the Affordable Care Act (discussed later in this chapter).

## Research on Care Transitions

Research on care transitions has shown persistent problems related to the movement of patients across settings, with resulting high hospital readmission rates. Studies of discharge

planning from hospitals to the community have found that approximately one-third of hospital readmissions could be avoided by instituting a more comprehensive system of transitional care (Coleman et al. 2006; Naylor and McCauley 1999). A 2013 study of nearly 400 patients discharged from a large academic medical center found that older adults were often confused about the discharge planning process. In the study, 96 percent of older adults reported knowing why they had been hospitalized, but only about 60 percent could accurately describe their primary diagnosis (Horwitz et al. 2013).

Additionally, research suggests that patients who receive post-acute care services following a major health episode see greater and more rapid clinical improvements compared to patients who are discharged to their homes without follow-up (American Hospital Association 2010). Interventions such as discharge planning, patient and family teaching, and home visits after discharge improve continuity of care and prevent poor health outcomes among older adults (American Hospital Association 2010; Coleman et al. 2006; Jack et al. 2009; Naylor et al. 2011; Naylor et al. 2004; Toles et al. 2012; James 2013).

Research has also focused on specific conditions causing hospital readmissions, the cost of readmissions, and reimbursement factors affecting discharge practices. A study by Ouslander and colleagues (2010) found that several common medical problems—cardiovascular conditions, respiratory conditions, acute mental changes, sepsis and fever, dehydration, skin conditions, and gastrointestinal disorders such as diarrhea—accounted for 95 percent of hospitalizations that were rated potentially avoidable. A 2011 study by CMS found that one in five Medicare beneficiaries who were discharged from a hospital were readmitted within 30 days, costing over $26 billion per year, with an estimated $17 billion (65 percent) of those costs deemed to be preventable (Betancourt, Tan-McGrory, and Kenst 2015; James 2013). A *Wall Street Journal* study of Medicare claims paid from 2008 through 2013 found that some hospitals discharge Medicare patients to nursing homes at particular times to maximize reimbursement for particular types of diagnoses and care (Weaver, Mathews, and McGinty 2015).

## Guidelines to Address Problems in Care Transitions

Older adults with multiple chronic conditions frequently experience inadequate care transition services. Lack of coordination and poor transition increases the likelihood of service duplication, care fragmentation, care delays, and medication errors, along with other adverse outcomes (Coleman et al. 2005; Schoen et al. 2011). Many patients transferred from acute care to post-acute care are quickly rehospitalized (Coleman and Boult 2003; Murtaug and Litke 2002).

These and other problems associated with transitional care planning have prompted the industry to suggest guidelines for effective transitions of care from acute to post-acute care settings. Recommendations from the National Transition of Care Coalition (NTOCC) are shown in exhibit 3.1.

## EXHIBIT 3.1

Recommendations from the NTOCC Measures Work Group on Transitions of Care Measures

**I. Structure:**

**A.** Accountable provider at all points of care transition:

Patients should have an accountable provider or a team of providers during all points of transition. The provider(s) would provide patient-centered care and serve as central coordinator(s) across all settings, and with other providers. This care coordination hub has to have the capacity to send and receive information when patients are transitioning between care sites. While the primary care patient-centered medical home incorporates such a hub, other practitioners can take this role as well.

**B.** A tool for plan of care:

The patient should have an up-to-date proactive care plan that would take into consideration the patient's and family's preferences and would be culturally appropriate. This care plan should be available to all providers involved in the care of the individual.

**C.** Use of a health information technology-integrated system that would be interoperable and available to both patients and providers

**II. Processes:**

**A.** Care team processes:

- Care planning ( including advance directives)
- Medication reconciliation (this process includes patient and family)
- Test tracking (laboratory, radiology, and other diagnostic procedures)
- Tracking of referrals to other providers or settings of care
- Admission and discharge planning
- Follow-up appointment tracking
- End-of-life decision making

**B.** Information transfer/communication between providers and care settings:

- Timeliness, completeness, and accuracy of transferred information
- Protocol of share accountability in effective transfer of information

**C.** Patient and family education and engagement:

- Patient and/or family preparation for transfer
- Patient and/or family education for self-care management (e.g., the NTOCC tools "My Medicine List" and "Taking Care of My Health").
- Patient and/or family agreement with the care transition (active participation in making informed decisions)
- Appropriate communication with a patient with limited English proficiency and health literacy.

**III. Outcomes:**

**A.** Patient's and/or family's experience and satisfaction with care received.

**B.** Provider's experience and satisfaction with the quality of interaction and collaboration among providers involved in care transitions.

**C.** Health care utilization and costs (e.g., readmissions, etc.).

**D.** Health outcomes consistent with patient's wishes (e.g., functional status, clinical status, medical errors, and continuity of care).

*Source:* Reprinted with permission from the National Transitions of Care Coalition, 750 First St., NE, Suite 700, Washington, DC 20002, www.ntocc.org.

## Laws and Regulations Affecting Care Transitions

CMS has implemented several Affordable Care Act provisions related to the coordination of transitions from acute to post-acute care. For example, Medicare will bundle reimbursement payments for episodes of care so that one payment for acute and post-acute services must be distributed to the providers participating in a patient's care. In addition, hospitals as well as post-acute providers can be penalized for seemingly preventable readmissions to acute care within 30 days of discharge. Additional provisions are discussed in the sections that follow.

### Community-Based Care Transitions Program

The ACA created the CMS **Community-Based Care Transitions Program** as part of the Partnership for Patients initiative. The program, which began in 2011, puts community-based organizations in charge of identifying the needs of Medicare beneficiaries who are moving from a hospital to their homes, as well as coordinating care to address those needs. It encourages partnerships between community-based organizations providing services to elders—such as Area Agencies on Aging, Aging and Disability Resource Centers, and Meals on Wheels organizations—with healthcare systems, long-term care communities, rehabilitation facilities, and other post-acute care providers. The program and other parts of the Partnership for Patients initiative aim to reduce hospital-acquired conditions among Medicare beneficiaries by 40 percent, reduce hospital readmissions by 20 percent, and improve the hospital discharge and care planning process (Hostetter and Klein 2012).

***Community-Based Care Transitions Program***
A Centers for Medicare & Medicaid Services program that helps community-based organizations form partnerships with healthcare systems, long-term care organizations, rehabilitation facilities, and other post-acute care providers. It aims to identify the needs of Medicare beneficiaries recently discharged from hospitals to their homes, coordinate the care of those individuals, and reduce hospital-acquired conditions and hospital readmissions.

### Accountable Care Organizations

Accountable care organizations (ACOs), as introduced in the ACA, provide models for the integrated delivery of healthcare services. ACOs are groups of providers and suppliers of healthcare and health-related services, along with others caring for Medicare beneficiaries, that voluntarily work together to coordinate care under the traditional Medicare program. The ACA enables ACOs that enroll a minimum of 5,000 Medicare fee-for-service beneficiaries to share in cost savings to the federal Medicare program under the Medicare Shared Savings Program (MSSP), based on ACO performance in improving quality and reducing costs (Medicare learning Network 2014). Some post-acute care providers have begun entering agreements with ACOs to establish and implement care protocols, to develop processes for care coordination and transitions, and even to integrate completely with acute care providers.

### CMS Bundled Payment Initiative Programs: The Comprehensive Care for Joint Replacement

In 2015, hospitals in 67 metropolitan areas were participants in the Comprehensive Care for Joint Replacement program, a mandatory CMS bundled payment program for hip and

knee replacement procedures. Under the conditions of the program, Medicare pays hospitals a flat rate payment for certain joint replacement procedures and allows patients to receive rehabilitative services in nursing homes after their procedures. Patients may be discharged to these nursing home post-acute care settings without the traditional minimum hospital stay of three days. Medicare's five-star rating system for nursing homes plays a key role in the care transitions, because only nursing homes with a three-star (average) rating or higher will be able to participate in the program as post-acute care providers. Nursing homes with lower Medicare star ratings may experience significant reductions in rehabilitation patient admissions and revenues, but the impact of the program on them remains to be seen.

### The Hospital Readmission Reduction Program

*Hospital Readmissions Reduction Program (HRRP)*
A program under the Affordable Care Act that requires the Center for Medicare & Medicaid Services to reduce payments to hospitals that have excess readmissions of discharged Medicare beneficiaries.

The Affordable Care Act added section 1886(q) to the Social Security Act, establishing the **Hospital Readmissions Reduction Program (HRRP).** This program requires CMS to reduce payments to hospitals that have excess readmissions from discharges that occurred after October 1, 2012, for specific diagnoses (CMS 2016). Hospitals will receive reduced payments from CMS if they have excess readmissions for acute myocardial infarction, heart failure, or pneumonia. In the Inpatient Prospective Payment System (IPPS) final rule for fiscal year 2012, CMS announced that elective hip and knee replacement surgery would be similarly monitored beginning in 2015 (CMS 2016).

In response to the HRRP, hospitals have trained their staffs to identify and track the potential of PAC services for patients with the conditions being tracked. Exhibit 3.2 shows the Risk Stratification Tool that one hospital has begun using.

CMS (2015b) has also published a Discharge Planning Checklist that it encourages patients and their caregivers to use when patients are about to be discharged from a hospital, nursing home, or other setting. The checklist encourages individuals to ask questions about their care, to set goals for themselves after discharge, to track their medications, and to make a list of follow-up appointments with healthcare providers.

### Working Toward Common Assessment

Policymakers and providers have agreed on the need for a single assessment with common data metrics used by all care transitions settings. A uniform assessment tool could help providers and patients work together to select the most appropriate post-acute care setting, encourage efficient data sharing among providers, and improve data analysis (AHA 2010). Consistent assessment could also help measure rates of hospital readmission across providers and inform the implementation of value-based payments for services to nursing homes in the future.

To better coordinate transitional care from hospitals to post-acute care and to improve data collection and analysis, industry leaders petitioned legislators to enact the Protecting Access to Medicare Act (PAMA) and the Improving Medicare Post-Acute Care

**EXHIBIT 3.2**
Coordination of Care Transition Risk Stratification Tool

| | |
|---|---|
| Patient has no Primacy Care Provider (PCP). | ❑ |
| Patient is 50 to 89 years old. | ❑ |
| Patient is single. | ❑ |
| Length of stay (LOS) > 5 days. | ❑ |
| Patient has diagnosis of acute myocardial infarction, pneumonia, or heart failure. | ❑ |
| Patient has > 1 emergency department visit in last 6 months. | ❑ |
| Patient has Medicare or Medicaid. | ❑ |
| Patient has history of depression. | ❑ |
| Patient has history of drug use. | ❑ |
| Score | __ |

Assessments with **5 or more** checked indicators are referred to Case Management for meeting with Transitional Care Coordinators.

*Source:* Vidant Health – Greenville, North Carolina. © 2015 Vidant Medical Center, All Rights Reserved.

Transformation (IMPACT) Act, both in 2014. The two acts complement each other by improving measurement of hospital readmissions and standardizing measures for resident assessment, resource use, and quality data.

***Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014*** Legislation requiring post-acute care (PAC) providers to report standardized patient and resident assessment data, data on quality measures, and data on resource use and other measures. The law also requires that the data be interoperable to allow for its exchange and comparison among PAC and other providers.

### The Protecting Access to Medicare Act of 2014

PAMA required that CMS specify an all-cause, all-condition hospital readmission measure for nursing homes by October 1, 2015, and an all-condition, risk-adjusted rate for potentially preventable hospital readmissions by October 1, 2016 (Senft and Larson 2015). As a result of this legislation, nursing homes will have uniform readmissions measures that they can use to compare their performance with that of their peers. By 2017, this readmissions performance data will be publicly available on the CMS Nursing Home Compare website. Collection and publication of nursing home readmission data, as well as other performance measures, will help determine value-based payment incentives for nursing homes.

### The IMPACT Act of 2014

The IMPACT Act of 2014 expanded data collection and reporting beyond nursing homes, as required by PAMA, to all post-acute providers. Specific IMPACT Act provisions include the following (Library of Congress 2014):

- Require PAC providers to report standardized data on patient and resident assessment, quality measures, resource use, and other matters
- Require the data to be interoperable to facilitate its exchange among PAC and other providers, to improve access to longitudinal information, and to help coordinate care and improve beneficiary outcomes
- Modify PAC assessment instruments for the submission of standardized patient assessment data for PAC providers and enable data comparison across providers

Ultimately, the IMPACT Act provisions will lead to a prospective payment system that promotes coordinated transitions of care that help patients achieve their goals and have quality outcomes. The act may also encourage the adoption and use of specialized technology, such as interoperable electronic health records, and health information systems by post-acute care providers to assist in data collection and reporting. Exhibit 3.3 shows the timeline for the implementation of IMPACT Act initiatives.

### The Proposed Discharge Planning Rule

In 2015, CMS proposed a rule that would require healthcare providers to develop personalized, detailed discharge plans for patients within 24 hours of admission (including a system for postdischarge follow-up and medication reconciliation) and complete the plan before transitioning the individual to the community or to another care setting. Individuals covered under this rule would include all Medicare inpatients; eligible outpatients, including individuals under observation status; and surgical patients and emergency department patients who need care transition plans. The proposed rule also includes planning for individuals with psychiatric or mental health diagnoses, including identification of mental health organizations able to form partnerships for behavioral health service provision (CMS 2015a).

**EXHIBIT 3.3**
Timeline of Major Deliverables in the IMPACT Act of 2014

| | |
|---|---|
| 2014–2016: | Hospital use of quality data to inform discharge planning |
| 2017: | Standardized quality and resource use measure reporting for PAC providers |
| 2019: | Standardized assessment data required for PAC providers |
| 2022: | CMS and MedPAC report on PAC prospective payment; study conducted on hospital assessment data |

*Source:* US Senate Finance Committee (2014).

## The Future of Care Transitions and Post-Acute Care Services

### Bundled Payments and Post-Acute Care Referrals

If bundled payment programs continue to grow under Medicare, hospitals and healthcare systems may try to direct patients to post-acute providers that are known for quality outcomes and low readmission rates. By funneling more patients to post-acute providers that achieve excellent results, hospitals will likely avoid penalties for excessive readmissions (Mullaney 2014). However, ethical dilemmas may emerge when a hospital or healthcare system attempts to limit competition through this type of referral system. The free choice of consumers to obtain post-acute care services, regardless of programmatic restrictions for reimbursement, is a key component of the US market-based healthcare and long-term care service delivery systems.

In addition, effective readmission-reduction strategies, such as the use of nurses or other transition coaches to follow up with patients after discharge, may be difficult for many organizations (particularly safety-net institutions) to afford. Medicare does not provide any direct payment to hospitals for transition coach services. As a result, the unreimbursed costs, together with reduced revenues from fewer readmissions, may raise doubts about the cost-effectiveness of hospitals' efforts to avoid readmission penalties (James 2013).

### Care Transitions and End-of-Life Care

Elders who have lived with multiple chronic illnesses for many years often have frequent readmissions to the hospital. One initiative seeking to address this issue is the Advanced Illness Management program, started in 2010 by California-based Sutter Health. The program provides an integrated service delivery model that advises individuals and their families about the transition to hospice and end-of-life services while the individuals still receive medical care in the community at home. An interdisciplinary team of healthcare professionals will consult with an individual and her family while she is in the hospital, and the team will institute a plan of approximately one year that shifts from acute procedures to palliative care services while also ensuring that a set of advance directives is in place.

Research has found that the Advanced Illness Management program reduced hospitalizations by 60 percent in the first 90 days of an individual's enrollment, reduced emergency room visits by 30 percent, decreased days in intensive care by 75 percent, saved payers approximately $5,000 per enrollee over the first 90 days, and generated consistently high patient satisfaction scores (Johnson 2014). The value of advance directives for elders with dementia was further highlighted by a 2014 study that linked advance directives to reductions in Medicare spending ($11,461 less per patient), likelihood of in-hospital death (17.9 percent lower), and use of the intensive care unit (9.4 percent lower) (Nicholas et al. 2014).

### Remote Monitoring Technologies

Some PAC providers have adopted innovative technologies such as telehealth and remote monitoring systems that can allow a team of registered nurses to monitor a resident on a 24-hour basis. A number of organizations are finding that these technologies can bring about cost savings, more effective resource utilization, and lower hospital readmission rates.

In 2013, the Centura Health at Home Demonstration in Colorado found that augmenting its program with telehealth services through a 24/7 clinical call center contributed to a 62 percent reduction in 30-day rehospitalizations related to congestive heart failure, chronic obstructive pulmonary failure, and diabetes. Rehospitalization rates for patients receiving telehealth home care (6.3 percent) were significantly lower than the rates for traditional home care patients (18 percent) (Broderick and Steinmetz 2013).

Similarly, in 2008, the implementation of a remote monitoring system in Minnesota's Northfield Retirement Community enabled administration to create more individualized care plans, use staff more effectively, and provide more intensive rehabilitation services to individuals who truly need them (Magan 2014).

### Supportive Social Services

As health systems are increasingly held accountable for health outcomes and for reducing the cost of care, they need tools and interventions that address patient and community factors contributing to excess utilization (Alley et al. 2016). Some providers have partnered with social services organizations to form **accountable health communities**, which provide supportive services such nutrition assistance, transportation, and housing needs and personal safety assessments to ensure the recovery of recently discharged individuals to their homes.

***accountable health community***
An association between healthcare providers and community-based social services agencies that promotes the safe discharge and recovery of individuals in their homes. Services may include home safety assessments, nutrition services, transportation assistance, and safety training.

Partnerships with Meals on Wheels programs have helped ensure adequate nutrition services at home for many recently discharged individuals. Meals on Wheels, Inc. of Tarrant County, Texas, for instance, developed a home-delivered meals program to support transitions from hospital to home within eight days of discharge. A study of the program found that client self-report of healthcare utilization (i.e., hospital readmission) at three months and six months was lower than expected given client characteristics (Cho et al. 2015). Some healthcare providers have also partnered with local Area Agencies on Aging to obtain transportation services for individuals who were discharged from the hospital and need rides to outpatient follow-up appointments.

In the years ahead, policymakers will have to closely monitor the impact of the Affordable Care Act reforms, Medicare's proposed rules, and various demonstration programs on care transitions. They also must be prepared to amend policies as necessary to ensure that reforms exert effective controls on spending without compromising the delivery of appropriate, personalized post-acute services (Grabowski et al. 2012).

## For Discussion

1. What are care transitions, and how are they related to care coordination?
2. Define subacute care and post-acute care, and describe the difference between the two types of services.
3. What is discharge planning, why is it important, and what types of care settings can patients be discharged to? (Name and describe at least two types of settings.)
4. What are some benefits of collaboration between acute care and post-acute care settings in the care transitions process?
5. Describe the role of acute care and community-based settings for care transitions. What types of community service providers should be contacted to assist in an individual's care transitions, especially if the individual lives alone?
6. What are transitions coaches, and why are they important in the care transitions process?
7. What are accountable care organizations, and how can they help the care transitions process and prevent hospital readmissions?
8. How can Medicare bundled payment programs help or hurt reimbursement for rehabilitation services in nursing homes?
9. What are PAMA and the IMPACT Act, and how can they help the care transitions process?
10. How can Medicare's proposed rules about discharge planning for patients in acute care settings, as well as involvement of caregivers in the care transitions process, benefit the Medicare beneficiary as well as the beneficiary's caregivers and loved ones?

## Case Study: The Case of Mrs. Flynn

Mrs. Flynn, a 68-year-old widow living alone in her home, was admitted to Community Medical Center after she became dizzy and fell while shopping for groceries. She broke her ankle in the fall. When interviewed by the hospital social worker, Mrs. Flynn admitted that she had not been taking her blood pressure medication on a regular basis and that her chronic obstructive pulmonary disease gave her difficulties when she would try to walk her dog in her gated community.

After six days in the hospital for ankle surgery and a week in the hospital's subacute rehabilitation unit, Mrs. Flynn was discharged home under the care of a home health agency. She was directed to take eight medications, three of which were brand new for her. Mrs. Flynn set goals for herself to monitor her blood pressure and to be able to walk her dog

daily. The goals of the hospital's care team were to control her high blood pressure and make sure that she could walk properly.

Once home, Mrs. Flynn's condition deteriorated quickly. The home health agency did not start its visits until five days after she had returned home. Mrs. Flynn's primary care physician was not informed that she had been hospitalized, and his practice's electronic medical record system was not compatible with the system used by Community Medical Center. Mrs. Flynn's two daughters—who lived two hours away and did not have a close relationship—could not coordinate how to manage her care, and her son, her primary caregiver, had to leave town on an unexpected business trip. Mrs. Flynn thus lacked transportation to her follow-up appointments, and her dog could only be walked once every two days by a neighbor in her complex. Mrs. Flynn had heard that a local community agency for seniors could drive her to appointments and get her a home-delivered meal, but she did not know whom to contact about such an arrangement.

When Mrs. Flynn had returned home, she was given a list of her medications; soon, however, she was not sure which of the medications to continue taking. She also could not afford all the medications, and she had no way of having the prescriptions filled and the medications delivered. Mrs. Flynn had limited food in her home following her hospital stay, and her son was reluctant to shop for provisions because his mother had not given him money to pay for them.

Mrs. Flynn became even more confused when she received her medical bills. She had no way of knowing what costs would be covered by Medicare or by her supplemental retiree health insurance from her deceased husband's employer. She was also having trouble walking with the walker given to her by the hospital, and she was becoming increasingly depressed because she could not walk her dog as she had done before. Mrs. Flynn became lonely and isolated. She also became afraid to go outside for any reason, because she feared she would become dizzy and fall and end up back in the hospital.

## Case Study Questions

1. Does Mrs. Flynn's situation resemble a typical transition home for hospitalized older adults? How could better communication between hospital staff, her care providers, her primary care physician, and community-based agencies have helped? What types of services might have been contacted and utilized during the transition?
2. How could Mrs. Flynn's children have been included in her hospitalization and discharge planning process?
3. What community-based agencies and organizations could have helped Mrs. Flynn with services during and after her transition back to the community?
4. Is Mrs. Flynn at risk for readmission to the hospital? Why or why not?

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