



LONG-TERM
QUALITY ALLIANCE

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care transitions improving the quality of life and care

for persons receiving
long-term services
and supports

2nd ANNUAL MEETING REPORT

HOSTED BY

Long-Term Quality Alliance

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MISSION STATEMENT

To improve the effectiveness and efficiency of care and the quality of life of people receiving long-term services and supports by fostering person- and family-centered quality measurement and advancing innovative best practices.

ACKNOWLEDGEMENT

The 2nd Annual Meeting of the Long-Term Quality Alliance (LTQA) was supported by a grant from the Agency for Healthcare Research and Quality (AHRQ). AHRQ is a government agency committed to improving care safety and quality by developing partnerships and generating the knowledge and tools required for long-term improvement. AHRQ's focus is on:

- 1 **Safety and quality**—reducing the risk of harm by promoting delivery of the best possible healthcare;
- 2 **Effectiveness**—improving healthcare outcomes by encouraging the use of evidence to make informed healthcare decisions; and
- 3 **Efficiency**—transforming research into practice to facilitate wider access to effective healthcare services and reduce unnecessary costs.

For more information, please visit www.ahrq.gov.

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BACKGROUND

More than 10 million Americans, including older adults and young adults with disabilities, rely on long-term services and supports. These numbers are expected to increase dramatically in the decades ahead.

Long-term services and supports are critical to helping vulnerable Americans maintain their health and wellness, improve their quality of life, and achieve independence in their activities of daily living. However, experts in the field have grave concerns about the availability, affordability, and quality of these services, both in the short-term and the longer term. These concerns have fueled interest in the value of fostering effective transitional care interventions for populations using long-term services and supports. The rationale behind this interest is that poorly executed care transitions can trigger adverse outcomes and add significantly to the cost of care.

Care Transition Trends

The American Geriatrics Society defines transitional care as “a set of actions designed to ensure coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location.”¹ These care settings can include hospitals, nursing homes, assisted living communities, private homes, and primary and specialty care offices.

Care transitions are prevalent among older persons and individuals with special needs. Consider these trends:

- **Vulnerable populations receive care in a variety of settings.** In 2000, adults aged 65 and older averaged more than 400 ambulatory visits, 300 visits to the emergency department, 200 hospital admissions, 46 skilled nursing facility admissions, and 106 home care admissions per 1,000 persons.²

- **Within these settings, multiple clinicians provide care.** In 2003, between 41.9 and 70 percent of Medicare patients admitted to the hospital for care received services from an average of 10 or more physicians during their stay.³
- **Transitions from hospital to nursing home are common.** One fifth (21%) of hospitalized patients 65 and older are discharged to a long-term care or other institution.⁴
- **Readmissions are prevalent—and expensive.** Between 20 and 23.5 percent of Medicare beneficiaries discharged from a hospital are readmitted within 30 days. Within 90 days, 34 percent of Medicare beneficiaries discharged from a hospital are readmitted. These readmissions cost Medicare between \$4.3 and \$26 billion a year.^{5,6,7}

The Impact of Poor Care Transitions

Minimal collaboration and communication across settings characterizes our nation’s health and long-term care systems. The resulting fragmentation is particularly problematic for older adults and individuals with special needs, including those with complex and chronic conditions, who receive services from multiple providers^{8,9} and move frequently between and among health care settings. Serious quality problems and adverse outcomes are most likely to affect this population of vulnerable individuals.¹⁰

Poor transitions undermine patient and family satisfaction and contribute to hospital readmissions and greater use of health care resources.^{11, 12}

Specifically, patient safety is jeopardized during care transitions by:

- High rates of medical and medication errors.
- Transfer of incomplete or inaccurate information across or between settings.
- Lack of appropriate follow-up care.
- Insufficient information about self-care management provided to the patient and caregiver.
- Minimal input and decision making by the patient and caregiver.
- Limited continuity of care due to health care providers' inability to access care plans.¹³⁻¹⁵

The Promise of Quality Transitions

In recent years, care transitions have captured the attention of both researchers and policy makers who remain convinced that successful transitions hold the greatest promise for improving quality and reducing health care costs for older adults at high risk for poor outcomes.^{16, 17}

Seeking to deliver on that promise, several initiatives have targeted care transitions as a priority for national action. For example, the Centers for Medicare and Medicaid Services included care transitions in the agendas for both the Partnerships for Patients and the 9th and 10th Scopes of Work. Care transitions are also addressed in the Affordable Care Act and are part of the work being carried out by the National Quality Forum.

LTQA Annual Meeting

The Long-Term Quality Alliance (LTQA) chose care transitions as the theme of its 2nd Annual Meeting in order to provide its members, partners, and other constituents with the knowledge and tools they need to participate in current initiatives aimed at improving these transitions. The meeting, held on Feb. 16, 2012 in Washington, DC, brought together a broad-based group of stakeholders, including:

- Consumers and family caregivers.
- Health service researchers.
- Evaluators and quality experts.
- Private and public purchasers of care.
- Foundations.
- Think tanks.
- Federal agencies that oversee issues relating to aging and health care quality.

This report summarizes key content presented during the meeting, including information about:

- Activities and recommendations of LTQA's quality improvement and quality measurement workgroups.
- Models and resources to enable organizations to achieve successful transitions across settings.
- Strategies to implement care transition interventions.
- Barriers to implementation of care transitions programs, and ways to overcome those barriers.
- Training needs of the workforce and strategies for educating staff about transitional care models.

CHAPTER 1: LTQA: PAST, PRESENT, AND FUTURE

Acknowledging Past Accomplishments

Mary Naylor, PhD, RN, FAAN

Past Chair, Long-Term Quality Alliance
Professor of Gerontology and Director,
NewCourtland Center for Transitions and Health
University of Pennsylvania

Many of us in the field of long-term services and supports (LTSS) have encountered patients like “007,” a participant in a recent University of Pennsylvania research project. When researchers met the patient they called 007, he was recovering from a stroke and had experienced multiple transitions in health and health care over 2 years. During a confusing and upsetting health-care journey, 007 transitioned from a nursing home to a Program for All Inclusive Care for the Elderly (PACE) and, finally, to hospice. Sandwiched in between these major moves were life-disrupting emergency room visits and hospitalizations.

Is this the way we would want to spend the last 2 years of our lives? The answer will most likely be a resounding “No!”

Unfortunately, we have good reason to believe that 007’s pattern of multiple transitions is not unique. That’s why it is critically important for us to understand how patients, residents, and clients perceive their experiences with the LTSS and health care systems. Then, we need to find ways to change those systems so they provide a more positive experience for the individual. Today’s meeting will be an important step in reaching those goals.

Two Years of Progress

LTQA is in a time of transition. I’m ending my 2-year term as chair of the Alliance as we welcome our new Chair Carol Rafael, past president and chief executive officer of the Visiting Nurse Service of New York. The past 2 years have been extremely productive and we have many accomplishments of which we can all be proud. Specifically:

- **Growing and learning:** Our experience developing LTQA over the past 2 years is analogous to flying an airplane while it’s still being built. It’s been challenging. But we’ve succeeded in capitalizing on immediate opportunities that affect people’s lives, while at the same time building a sustainable infrastructure so LTQA can move forward.
- **Active workgroups:** LTQA created three workgroups that are focusing their efforts on the national priority of improving care transitions. These workgroups include:
 - The Quality Measurement/Key Indicators Workgroup, which is charged with advancing meaningful measurement of key person- and family-centered quality indicators. This workgroup has focused on care transitions as a way to reduce avoidable hospitalizations for adults requiring long-term services and supports.
 - The Quality Improvement/Best Practice Workgroup, which has focused its attention on the dissemination and adoption of person- and family-centered, evidence-based practices that apply to care transitions and reductions in avoidable hospitalizations.
 - The Outreach/Public Awareness Workgroup, which has succeeded in raising the awareness of LTQA among the public and other key stakeholders.

- **At the table:** LTQA members and board members sit at key policy tables at the national and state level. They use these positions to inform stakeholders about people who receive LTSS and to promote collaborative efforts aimed at improving quality of life and care for these individuals.
- **QIO partnerships:** LTQA has partnered and aligned forces with quality improvement organizations (QIOs) focused on the issue of care transitions. Together LTQA and QIOs have worked to enhance the experience of individuals who receive long-term services and supports.

Setting Future Goals

Carol Raphael

Chair, Long-Term Quality Alliance
Past President and Chief Executive Officer,
Visiting Nurse Service of New York

Over the next 2 years, the Long-Term Quality Alliance will build on the great successes we've achieved under the leadership of Dr. Mary Naylor, whose contributions to the Alliance are numerous.

LTQA represents a broad spectrum of individuals and organizations including consumers, providers, health plans, policy makers, thought leaders, and representatives of a variety of government agencies.

This unique mix of stakeholders allows the Alliance to bring different perspectives to bear on its efforts to strengthen and integrate the LTSS and health care systems. Our goal is to ensure that these systems produce better outcomes and experiences for people while also becoming more cost effective.

As we look to the future, LTQA intends to build on our care transitions work to date. As we continue to conduct a broad examination of the health and LTSS systems, our work will fall into two broad categories:

1. LTQA will showcase and disseminate the work that our members are carrying out, both individually and collaboratively. Through these activities, we intend to demonstrate the kinds of changes that are possible, how those changes can best be implemented, and how they will reform our current care systems.
2. LTQA will redefine quality by placing the consumer—whether we call that individual a patient, resident, or family caregiver—at the center of the nation's care delivery systems. Together with these consumers, we will work hard to incorporate a broad range of long-term services and supports into the quality equation.

CHAPTER 2: MEMBER AND WORKGROUP UPDATES

Patient-Centered Outcomes Research Institute

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The Patient-Centered Outcomes Research Institute (PCORI) is an independent, non-profit organization created by Congress in 2010. PCORI-funded research provides patients, their caregivers, and clinicians with the evidence-based information they need to make better-informed health care decisions. PCORI's board represents a broad range of stakeholders, including:

- Patients.
- Caregivers.
- Physicians, nurses, and clinicians.
- Hospitals and health systems.
- Health plans.
- Health services researchers.
- State and federal health officials.
- Pharmaceutical, device, and diagnostic manufacturers.
- Private payers.
- Employers.

The PCORI Research Agenda

Federal legislation established PCORI's research priority areas. In addition, stakeholders have opportunities to provide input into the institute's research agenda. Current priorities include:

1. Assessing options for prevention, diagnosis, and treatment options.
2. Improving health care systems.
3. Conducting communications and disseminations research that explores how to better reach out to doctors, patients, and family members.
4. Addressing disparities among minorities, women, children, and others.
5. Accelerating patient-centered outcomes research and methodological research.

Request for Proposals

During 2012, PCORI will have \$112 million available to fund research projects in its priority areas. A Request for Proposals for PCORI-funded research initiatives will be available in May 2012. PCORI will announce its grant awards in December 2012. Research findings will be disseminated to patients as well as physicians, occupational therapists, and others who work with patients.

Quality Improvement/ Best Practices Workgroup

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Co-Chair, Quality Improvement/
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The Quality Improvement/Best Practices Workgroup convened two Innovative Communities Summits during the past 2 years. The Summits—which took place in December 2010 and June 2011—attracted organizations and individuals concerned about and committed to advancing change within the nation’s health care system in order to improve effectiveness and efficiency of care and quality of life while saving health care dollars.

LTQA’s Innovative Communities initiative is based on the Alliance’s strong belief that a broad range of community stakeholders—including physicians, hospitals, Area Agencies on Aging, long-term and post-acute care providers, visiting nurses, affordable housing providers, adult day health programs, home care agencies, and consumers, to name only a few—is needed to help older people and people with disabilities remain healthy and independent. Health care reform will not succeed in reaching its goals unless all of these local stakeholders pool their collective energy, break down the silos in which they operate, and work together as Innovative Communities to devise and implement strategies and interventions that advance and improve care. Those strategies and interventions must be aligned with the needs, preferences, and values of consumers and their family caregivers.

Identifying Best Practices

Participants in Innovative Communities can work together to focus on care transitions, that critical time in an individual’s health care journey when quality of life is often lost and money is most likely to be wasted. To assist Innovative Communities in this effort, a national scan identified:

- Specific organizations that are implementing programs to improve care transitions.
- The sectors and settings in which these programs operate.
- The populations served by these programs.
- Opportunities for LTQA to help these programs include long-term services and supports (LTSS) in their focus.

The scan yielded valuable information about care transition programs being carried out by a variety of hospitals, community teams, skilled nursing facilities, medical homes, and aging services providers. We learned about a variety of transition-related interventions that involve the use of health information technology; engage the public-at-large as well as patients/residents/clients and caregivers; and involve LTSS providers and providers of housing with services.

Growth in Care Transitions Programs

In 2007, there were only a few pilot programs that revolved around care transitions, including:

- **Project Re-Engineered Discharge** (Project RED), based at Boston University Medical Center. Project RED develops and tests strategies to improve the hospital discharge process in a way that promotes patient safety and reduces rehospitalization rates.

- **Better Outcomes for Older Adults through Safe Transitions** (BOOST), a national initiative led by the Society of Hospital Medicine. BOOST seeks to improve the care of patients as they transition from hospital to home.
- **State Action on Avoidable Rehospitalizations** (STAAR), a multi-state, multi-stakeholder approach reduces rehospitalizations by working across organizational boundaries. STAAR engages payers; stakeholders at the state, regional and national level; patients and families; and caregivers at multiple care sites and through multiple clinical interfaces.

Today, several hundred care transition programs are being implemented in various settings and locales. This exponential growth is due, in part, to the federal government's new emphasis on improving care transitions. A number of federally supported initiatives are taking place across the country, with activities in some areas more robust than others.

LTQA Efforts

The Quality Improvement/Best Practices Workgroup is considering what can be learned from current care transition activities and is trying to understand how to help less-active areas of the country improve these transitions. To date, LTQA efforts have focused on:

- Engaging LTSS providers in its efforts.
- Helping stakeholders focus on addressing the population using long-term services and supports.
- Expanding its view of care transitions beyond the Medicare population or individuals with specific diagnoses.
- Serving as a champion for the consistent inclusion of the person and/or caregiver.

CMS Innovations Grant

On behalf of LTQA and LeadingAge, the Quality Improvement/Best Practices Workgroup recently applied for an Innovation Grant from the Centers for Medicare and Medicaid Services (CMS). If funded, the grant would support the launch of an Innovative Communities Initiative (ICI) designed to help 300 LTSS providers create Innovative Communities that improve care coordination across settings for high-risk residents/clients. The ICI's specific aim would be to reduce emergency department and hospital utilization by 20 percent over 3 years. To accomplish that goal, it would provide technical assistance and modest resources to participating Innovative Communities and would also work to build the capacity of the LTSS workforce so it can engage in improvement efforts that span a variety of settings. The grant would also involve an evaluation of the ICI and the development and delivery of resources addressing:

- Change management.
- Action-oriented improvement skills.
- Best practices and enabling technologies that can help reduce emergency department/hospital use for the target population.

Quality Measurement/ Key Indicators Workgroup

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The Quality Measurement Workgroup faced many challenges as it selected and recommended quality measures and identified measurement gaps relating to care transitions. These challenges are directly related to the complexity of care transitions, which:

- Take place within a fragmented health care system and across multiple settings and environments.
- Involve multiple subpopulations and people with multiple health issues and chronic conditions.
- Require the active involvement of family members.

The Quality Measurement Workgroup focused on measures that prioritized older adults. The group's work did not include measures affecting young adults with disabilities.

Three Measurement Domains

The Quality Measurement Workgroup initially conducted a broad scan of existing measures, coupled with a scan of the transitional care literature, to identify three key domains for measuring transitional care processes and outcomes among older adults receiving long-term services and supports. Each domain reflects and relates to one or more of the Institute of Medicine's aims for quality improvement that strives for health care that is safe, effective, person-centered, timely, efficient, and equitable. The domains are:

1. **Person- and Family-Centeredness**, defined by the Institute of Medicine as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions."¹⁸
2. **Transitional Care Processes**, defined by Naylor et al as "a broad range of time-limited services designed to ensure health care continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another."¹⁹
3. **Performance Outcomes**, defined by Donabedian as "measurable endpoints of long-term services and supports with a particular emphasis on economic, utilization, and clinical complications."²⁰

Using an iterative consensus process, the Quality Measurement Workgroup produced 12 recommended measures. Transitional Care Processes, with 10 recommended measures, was the most robust domain. The workgroup recommended fewer measures in the Person- and Family-Centered domain and the Performance Outcomes domain.

Identified Gaps

In Dec. 2011, the Quality Measurement Workgroup released a report entitled *Measurement Opportunities and Gaps: Transitional Care Processes and Outcomes among Adult Recipients of Long-Term Services and Supports*. The report identified more gaps in transitional care measurement than recommended measures. Specifically, health care and LTSS systems need the following measures and actions:

- Person- and family-centeredness measures that go beyond clinical outcomes.
- Process and outcome measures for older adults with cognitive impairment and those receiving palliative care.
- Transitional care management across episodes of care, including multiple settings and multiple outcomes.
- Discharge readiness and social support, including the engagement of individuals and families beyond the walls of discharging organizations.
- Preventive care for those in transitions, particularly around functions and improvement of functions.
- Access to, cost, and cost-effectiveness of transitional care.
- Testing of bundled sets of recommended measures to determine whether they yield meaningful information for quality improvement and consumer selection.

Measure Applications Partnership

The Measure Applications Partnership (MAP) is a public-private enterprise convened by the National Quality Forum (NQF) to:

- Provide input to the Department of Health and Human Services (HHS) on selecting performance measures for public reporting, performance-based payment programs, and other purposes.
- Identify gaps in measure development testing and endorsement.
- Encourage alignment of public and private sector programs.
- Align measurement across levels of analysis and settings to promote coordination of care delivery and reduce the data collection burden.
- Coordinate with and reinforce other efforts for improving health outcomes and health care quality.

In past years, HHS has issued rules on performance measurement one health care program or initiative at a time. As a result, measures in different programs vary widely. In Dec. 2011, however, HHS changed its approach by seeking broad input on a list of more than 350 measures and potential measures under consideration for use in clinician, hospital, and post-acute care/long-term care measurement programs. The new list represented an attempt by HHS to create a process that deliberately encouraged a cross-program and coordinated look at the measures used in public programs.

MAP was charged with evaluating these measures and providing input to HHS on which measures could be optimally deployed in 2012 federal rules for improvement and accountability purposes. However, MAP's report identified more gaps than measures that met its criteria for endorsement. A concerted effort is needed to address these gaps.

The HHS-promulgated measurements fall into four areas:

Person- and family-centered care: This area, one of NQF's priorities, is designed to better align health care with the needs and preferences of the individual. It seeks to produce the best outcomes for individuals and populations in accordance with their values and preferences. The new measures assess whether care was consistent with the individual's choices and resulted in better health outcomes over time.

Care coordination: These measures provide an opportunity for aligning performance measurement across multiple settings and programs with the help of bi-directional information exchange and shared accountability among providers. MAP has encouraged adoption of additional measures relating to coordination of care that focus on care transitions, readmissions, and post-discharge medication reconciliation.

Dual eligible beneficiary population: This MAP priority area could benefit from a person- and family-centered approach to care and related quality measurement. Federal programs that focus on a single setting or type of health care have reduced the ability of providers to promote health care quality across the continuum. The adoption of new measures offers an opportunity to step back and see how these measures can apply across different payment programs and care settings.

Post-acute and long-term care: Performance measurement across post-acute care (PAC) and long-term care (LTC) settings is fragmented due to the heterogeneity of patient populations and varying performance measurement and reporting mechanisms from one setting to another.

A coordinated performance measurement strategy across PAC and LTC providers would help promote safe, efficient patient-centered care. MAP identified six high-leverage areas of measurement for PAC and LTC providers, including:

- Function.
- Goal attainment.
- Patient engagement.
- Care coordination.
- Safety.
- Cost/access.

Within each priority area, the partnership identified a core set of measurement concepts. A MAP evaluation found that few performance measurement programs met the criteria for NQF endorsement.

Defining Quality

The process of defining quality raises a number of questions including:

- What are you measuring?
- What and to whom are you comparing quality?
- What can health and functional decline tell us about quality?

Measurement and rewards should be based on what matters most to patients and should include measuring how well people feel and how adept the system is at helping patients get what they want. The best care requires a concerted effort among many people working together and communicating effectively with patients, families, and each other. Consistently good outcomes require good processes of care and measurement, and should include both process and outcome measures.

For More Information

These additional resources are available:

Quality Measurement Workgroup Report: Measurement Opportunities and Gaps provides more information about the Quality Measurement Workgroup's recommendations.

Input on Measures under Consideration by HHS for 2012 Rulemaking is MAP's final report on the HHS measures.

Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement outlines a performance measurement coordination strategy for a subset of PAC and LTC providers. This strategy is one way to align measurement across settings, reduce data collection burdens, and facilitate patient-centered, coordinated care.

CHAPTER 3: GENERAL SESSIONS

Promoting Effective Transitions among Long-Term Care Recipients: Maximizing on Health Reform Implementation

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The Affordable Care Act (ACA) holds both opportunities for and threats to care coordination.

On the plus side, the health reform legislation contains three provisions designed to advance care integration for the population of adults coping with chronic illness. In addition, the ACA authorized funding for several initiatives that promise to improve care transitions. This support was driven by a new and growing awareness of transitional care that has been promoted, in part, by the work of Dr. Mary Naylor. The ACA also shines a welcome spotlight on issues relating to long-term services and supports (LTSS), particularly around care transitions and hospital admissions.

It is important to note that the ACA also has limitations. Many of the law's provisions may contribute to increased fragmentation within the health care system and among those caring for this vulnerable subgroup. In addition, more effort and work is required to improve care and reduce costs.

Unfortunately, while the ACA supports a variety of programs that examine different aspects of the health care system and the person, it does not address the whole person or the costs of public programs, particularly as they relate to people requiring long-term services and supports. In fact, LTSS providers are largely ignored in the ACA, as many provisions focus on hospital readmission penalties and bundled payments for hospitals.

This emphasis on hospitals shows a lack of understanding about transitional care issues. Indeed, hospital readmission rates are affected by many providers that are not hospitals. Consider the fact that more than one-fifth of people admitted to nursing homes will be sent to the hospital within the first 6 months after nursing home admission.

States are attempting to establish programs that provide comprehensive care for Medicare and Medicaid beneficiaries, but they struggle with implementation because few good models have been successful. Accountable care organizations have been effective in bringing about improved quality at a lower cost, but many of these initiatives have not focused on very frail and vulnerable patient populations with multiple chronic illnesses and medical problems. This is a mistake. Unless health reform focuses squarely on addressing the needs of frail older adults, it will be difficult to move the health care system toward better quality and lower costs.

Recommended ACA Provisions and Future Policy Direction

How can the Affordable Care Act be strengthened so that it truly supports transitional care? These future policy directions hold promise:

- **Enhanced support for caregivers:** Family caregivers and the paid caregiver workforce must be supported through resources and training. Training cannot be limited to staff members who are directly involved in care transitions. Rather, all staff in the “transitional care loop” should

receive training. In general, the ACA should include more provisions focused on the workforce. At the very least, workforce provisions currently included in the law must be funded.

- **Fully integrated, capitated payment models:** These payment models should apply to all health care programs; otherwise, each program will draw from one set of resources and will not be able to provide adequate support to individuals with health care needs. For example, more unified financing across Medicare and Medicaid could enhance the coordination of care and improve the experience of care for people who are dually eligible for both programs. The Program of All-Inclusive Care for the Elderly is a notable example of this approach.
- **Bundled payments for long-term services and supports:** The health care system is in need of a more explicit model for implementing bundled payments and other reforms and expanding them beyond acute care. These payment reforms should feature financial incentives and quality measures.
- **A move beyond acute care:** The health care system must offer lifelong support to people with chronic conditions who experience multiple transitions and cycles of transitions. To achieve this goal, transitional care must extend beyond the first 30 days after hospital discharge and should focus on helping consumers manage their own care through such strategies as education about self-care and support for family caregivers.

- **A comprehensive approach to payment reform:** For the most part, pilot programs that test payment reforms have not been proven effective because they are generally implemented on a short-term basis and focus on bringing about small, rather than systematic, changes. As an alternative, true health reform will focus on implementing a comprehensive approach to payment reform that integrates care for patients who are frail and have multiple chronic conditions. Such an approach will bring about real change and will succeed in lowering the cost of long-term services and supports.

Nursing Homes and Care Transitions

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What constitutes a preventable hospitalization? Up until now, that determination has been made by examining diagnostic codes from administrative data. A different, albeit more labor-intensive, approach to defining preventable hospitalizations is the implementation of structured medical record reviews by experienced clinicians. Unfortunately, while this approach would constitute a good quality-improvement strategy, it is not administratively viable.

Numerous factors and incentives influence the decision to hospitalize a patient and, in the process, impact the definition of “preventable,” “avoidable,” and “unnecessary” hospitalizations. These factors and incentives include:

- **Medicare reimbursement policies.** These policies offer an economic incentive to hospitalize patients.
- **Consumer preferences.** Patients and their families need education about the risks and benefits of hospitalizations.
- **Access to palliative and hospice care.** Hospitalization decisions could be affected by the availability of individual patient advance care plans and physician orders for this type of care.
- **Legal issues.** Many practitioners have concerns about legal liability and the possibility of regulatory sanctions if they attempt to manage acute illnesses in a non-hospital setting. Such concerns could influence the decision to hospitalize a patient.
- **Emergency department (ED) issues.** These might include ED time pressures and the availability of community-based care options after ED discharge.
- **Nature of home and long-term care institutional services.** Homes and institutional long-term care settings lack the capacity to offer people with serious illnesses access to the care they need. Specifically, these settings often do not have diagnostic and pharmacy services, trained medical doctors, nurse practitioners, physician assistants, registered nurses, and personal care assistants available. In particular, nursing homes need a baseline capacity to care for people who have illnesses that might otherwise prompt a hospital admission.

A literature search on potentially preventable hospitalizations did not identify any appropriate quality measures for frail and chronically ill adults and older people, or measures that distinguish which hospitalizations are potentially preventable for the population served by LTSS providers. One promising approach to more accurately defining the nature of rehospitalizations may involve measuring unplanned admissions only, rather than all readmissions. In addition, tracking “observation stays” could help clinicians measure unavoidable hospitalizations.

Models to Prevent Unnecessary Rehospitalizations

Two programs stand out as models in the national effort to reduce unnecessary rehospitalizations:

Interventions to Reduce Acute Care Transfers

(INTERACT): INTERACT is a quality improvement program designed to improve early identification, assessment, documentation, and communication of changes in the status of residents in skilled nursing facilities. The program’s design was initially supported by the Centers for Medicare and Medicaid Services; the program currently operates with help from a Commonwealth Fund grant. INTERACT is designed to improve care and reduce the frequency of potentially avoidable transfers to the acute hospital by:

- Preventing conditions from becoming severe.
- Managing some conditions in the nursing home.
- Improving advance care planning.

INTERACT is based on the philosophy that caregivers who are trained in transitional care protocols have a critical role to play in helping nursing homes and their residents avoid unintended consequences. The program features evidence-based and expert-recommended clinical practice tools, and educational resources that caregivers can use in their daily practice. This includes an acute transfer log that calculates and benchmarks data as a way to track quality improvement.

The INTERACT project team is in the process of developing a strategic plan to:

- Disseminate the program.
- Enhance its curriculum.
- Train coaches to help organizations implement INTERACT.
- Conduct a randomized trial to further the evidence-base.

Alta Project at Valley Grande Manor: Valley Grande Manor is a 162-bed nursing home in Brownsville, TX, that involves all levels of staff in its efforts to decrease rehospitalizations and improve the lives of residents. Readmissions are a concern for the facility because they cause pain and suffering for the resident, interrupt the quality care and staffing provided by the nursing home, and represent an unsustainable cost. Key elements of the Alta Program include the following:

- **Administrative control:** The facility’s medical director controls care transitions through a protocol that serves as a checklist of interventions that must take place during a transition. Three teams—Care Transitions, New Resident, and Specially Trained Nursing—implement the program and conduct root cause analysis to address any system problems.
- **Clinical protocols:** The Specially Trained Nursing Team (STNT) uses clinical protocols to address the most common issues that are likely to arise in the skilled nursing setting. Through STNT, one nurse per shift receives training to improve assessment, documentation, critical thinking, and compliance. The program focuses on expanding critical thinking skills as a way to help nurses detect changes that would indicate a person’s health is declining.

- **Special focus on new residents:** The New Resident Team consists of the director of nursing, pharmacist consultant, dietitian, certified nursing assistant director, Minimum Data Set (MDS) nurse, and medical director. The team prevents hospital admission among new residents by evaluating these residents when they arrive at Valley Grande Manor, documenting their medical conditions, and monitoring them closely.
- **Ongoing documentation:** The program tracks hospital readmissions and graphs the number of rehospitalizations within 30 days.

Community-Based Settings and Care Transitions

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San Francisco Transitional Care Program: A Collaborative Model

The San Francisco Transitional Care Program started in 2002 as a partnership between San Francisco Senior Center and Saint Francis Memorial Hospital. The program uses a dedicated case manager to improve the discharge process from the hospital to the home for at-risk, low-income seniors. Seven community partners participate in the program by providing services to all of the city's hospitals.

Program elements: A gap analysis conducted prior to the program's launch revealed a dearth of data about the care transition services provided to hospitals by different groups. To fill this gap, the program:

- Implemented a centralized referral process for discharge planners at all San Francisco hospitals, along with a dedicated case management system.
- Provided training and orientation for hospital staff.
- Created a presence for the program at each hospital.
- Provided feedback about outcomes to discharge planners in order to increase job satisfaction and ongoing relationships.

Adding to the knowledge base: Over the past 10 years, clients served by the Transitional Care Program have reported improved health status and a clearer understanding of medications, equipment, and health care needs. This success can be attributed to a number of factors, including the ability of the program to add to the knowledge base about transitional care. The knowledge-building process includes:

- Identifying the key service needs of its clients so the Transitional Care Program can target available funds more efficiently and build community capacity to fulfill the most pressing service needs. Clients make the most use of six services: in-home supportive services, medications management, medical appointments, transportation, housing, and home care.
- Creating a demographic profile of the at-risk population served by the program so providers know their clients better.
- Developing a database of patients, and using standardized forms to add information to that database.

- Conducting a root cause analysis of 30-day readmissions among eight hospitals. This analysis showed that patients readmitted to the hospital had psycho-social issues (46%), were readmitted prior to a follow-up physician appointment (58%), returned home without any services (53%), had polypharmacy issues (83%), or did not understand their discharge instructions once they were home (38%).

Collaboration: Partnerships are a key to the program’s success and those partnerships have been strengthened through a formal oversight committee for community-based organizations and agencies, as well as systems to promote communication between those organizations and hospitals.

Recommendations: Those interested in establishing a Transitional Care Program should:

- Select community partners with a similar vision.
- Assess partnership capacity and the unique needs of the communities served.
- Develop a memorandum of understanding to formalize partners’ commitment to service goals.
- Build a sustainable process for funding.
- Implement training programs that are specifically designed for transitional care case managers, and address the oversight process.
- Continue to track the usage of transitional care services in order to understand the community’s changing needs.

Pennsylvania Department of Aging: Administration on Aging Care Transition Program

The Administration on Aging (AoA) partnered with Area Agencies on Aging (AAA) to develop Aging and Disability Resource Centers (ADRC) that serve

as single-access points for long-term services and supports in particular regions. Through the ADRC program, AoA funded 16 states, including Pennsylvania, to implement evidence-based models that facilitate care transitions.

Prior to the launch of the Care Transition Program, Pennsylvania’s hospitals and AAAs did not work collaboratively. Typically, a hospital informed its local AAA about its needs at the last minute and viewed the AAA as a “menu of services to be delivered.” To rectify this situation, Pennsylvania organized a meeting of AAAs, hospital administrators, and hospital discharge planners to begin discussions about how they could work collaboratively to address the issue of care transitions.

Subsequent to this meeting, Pennsylvania received an ADRC Options D grant from AoA to operationalize Dr. Mary Naylor’s Transitional Care Model in collaboration with Crozer Keystone Health System. The health system is comprised of five hospitals and a comprehensive physician network of primary-care and specialty practices in Delaware County.

How the Program Works

The Delaware County Care Transition Program provides comprehensive discharge planning and assessment, along with intensive in-home follow-up by a nurse. The program is designed to reduce rehospitalizations for a minimum of 235 high-risk seniors. Assessors from the Delaware County Office of Services for the Aging work at the hospital to identify and engage older adults most at risk for rehospitalizations. An APN/home care nurse monitors these patients upon discharge to ensure that their needs are met during the transition from acute care to community-based settings. The AAA care manager continues the follow-up with patients and coordinates any needed services.

Patient surveys have revealed an overwhelmingly positive response to the program. Most patients are satisfied with the services they receive, and a majority reported that they received care instructions, had

access to needed medical equipment and supplies, and had their needs met by home-based services. In addition, most respondents said that they were included in discussions about managing their care and that their questions and concerns about follow-up services had been answered.

Program sponsors learned several lessons while establishing and operating the Care Transition Program, including the importance of:

- Setting and maintaining standards for selecting patients who are appropriate for the program.
- Ensuring that patients are followed by a single case manager.
- Educating home care nurses about the availability of an APN for patients with high acuity.
- Providing adequate training for staff members who interact with patients in the program.

Workforce Education on Care Transitions

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The Direct Care Worker's Role in Transitional Care

Direct care workers provide the majority of hands-on care to, and have established relationships with, residents and clients; they also have more interaction with family members than most other providers of long-term services and supports. Given their important role in the lives of older adults and their families, these workers are in an ideal position to help residents and clients avoid hospitalizations and transfers to other settings, and to ensure the continuity of care across settings.

Direct care workers can enhance their participation in transitional care by serving on multi-disciplinary teams and acting as liaisons between family members and health care professionals. In addition, these workers can enhance client/resident compliance with treatment regimens by engaging in greater task delegation in relation to such interventions as medications management and wound care.

Barriers to full participation of direct care workers in care transitions include:

- **Lack of awareness and acknowledgment.** For the most part, direct care workers are invisible and unknown to hospitals, despite the fact that they have the most involvement, after the family, in care transitions. In addition, clients and consumers don't acknowledge the fact that direct care workers are part of the care transitions team.
- **Variation in scope of practice among states.** Certain states set scope-of-practice limitations that prevent direct care workers from carrying out such tasks as conducting assessments and dispensing medications. These regulations represent a significant obstacle to care transitions. Specifically, they prevent hospitals from maximizing the potential of these workers, who could be valuable members of care transition teams.

- **Lack of training and skill development.** In general, current competencies and training requirements do not have a specific focus on transitional care. However, it should be noted that some state training requirements contain elements that could become best practices in facilitating improved care transitions. In addition, programs like INTERACT and the Medicare Quality Improvement Organization (QIO) for Home Health have developed training and educational materials that promote the involvement of direct care workers in transitional care. For example, INTERACT's Stop and Watch tool helps direct care workers recognize and document early signs of risk for hospitalization. Such tools can empower frontline staff and are an important piece of the care transition puzzle. In addition, the Home Health QIO Support Center offers a training module on care coordination for direct care workers.
- **Inadequate reimbursement.**

Transitional Care: Education to Improve Quality and Cost Outcomes

The Naylor Transitional Care Model facilitates a partnership among the person transitioning from the hospital to home, his or her family, and providers of health care and long-term services and supports.

Typically, the individual at the center of the care transition has multiple health problems and unique needs. The model's most effective tool in meeting these needs is one APN who provides a consistent presence in the life of the individual. Observers question whether the model's use of an APN is realistic, given the current APN shortage. They suggest that a registered nurse could substitute for the APN, as long as needed support systems are in place.

The Naylor Transitional Care Model comes with training modules supplemented by readings and practical experience. Because team members require ongoing peer support, the education program must be

supplemented by a supportive network of colleagues that provides staff members with opportunities to talk and brainstorm about issues among themselves. In addition, guidance from transitional care experts helps to build on staff's clinical knowledge.

An Integrated Academic and Field Learning Project for MSW Candidates Working with Persons with Mental Health Conditions: Considering Adaptations for the Long-Term Care Workforce

A training program for graduate social work students at Columbia University School of Social Work could help inform education and training for providers of long-term services and supports. The Evidence Based Practice Project for Persons with Severe Mental Health Conditions was designed to provide graduate-level Master of Social Work with an opportunity for integrated academic study and field internships.

Field internships are a key component of the program. Students study and apply evidence-based practices in supervised field settings that are vetted by the New York State Office of Mental Health. A similar field-study model could readily be adapted to the LTSS field by preparing students from a range of disciplines—including nursing, psychology, or occupational, recreational or physical therapy—for careers in the long-term care workforce.

Adapting the Columbia University program to the LTSS field would require a large measure of collaboration from a variety of stakeholders, including academics in a particular discipline, practitioners and leaders in the field, and policy makers in local and state government. Collaborators would work together to develop an innovative and integrated curriculum that would span the classroom and the field and could be sustained and regularly updated over time.

Implementing Care Transitions

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Effective implementation is critical to the long-term sustainability of any care transitions program. Implementation plans should have a number of goals:

- Educating and training staff.
- Empowering staff members to participate as fully as possible in the program.
- Integrating the program into everyday practice.
- Making the program a permanent and key part of the organization's quality improvement activities.

The implementation process takes time and requires initial buy-in from a facility's leadership and staff. Buy-in also needs to come from the medical director as well as primary care providers. Input from those who use and will be affected by the program can help secure that initial buy-in.

While education of staff is critical to the success of programs, education alone will not change the organizational environment. Incentives and tools are also needed. In some settings, a tool designed for use

by all staff—including housekeeping, dietary, and certified nursing assistants—can be effective as long as organizational culture does not prevent direct care workers from properly using the tool.

In order for transitional care models to be successful and sustainable, program organizers must:

- **Appoint and train multiple champions.** This reduces problems with sustainability if one champion leaves the organization. Embedding tools and protocols into everyday practice will also help overcome staff absences and turnover.
- **Train staff so they can participate fully in the program.** Be sure every new staff person undergoes the same training.
- **Measure success.** Track and benchmark changes in the rate of hospital transfers.
- **Work closely with physicians and emergency department staff.** Make it a priority to improve communication and management of acute changes in condition.
- **Educate families about the risks and benefits of hospitalization.** This should reduce the incidence of families requesting a hospital stay for a loved one.

Next Steps in Care: Involving Family Caregivers in Transitions

Family caregivers are essential participants in transitional care plans. Their role must be explicitly recognized and they must be involved in discharge planning. In addition, it is crucial to discuss with family members any barriers they see to fulfilling elements of the care plan. Once that plan is established, family members must receive support and training that is ongoing, rather than a one-time event. These caregivers require early preparation and post-discharge follow-up to ensure they absorb all the information and instructions given at discharge.

The Next Steps in Care program operated by the United Hospital Fund is a multi-year, multi-dimensional campaign designed to change health care practice by routinely recognizing, training, and supporting family caregivers, especially at times of transitions in care. The program informs and educates caregivers of chronically ill patients so they can become equal partners with providers in caring for the patient. This goal is accomplished through direct outreach to caregivers and through a learning collaborative. In addition, program staff works with community agencies to ensure that their staff members are adequately trained to intervene with caregivers before a crisis occurs.

The United Hospital Fund launched the learning collaborative, called Transitions in Care–Quality Improvement Collaborative (TC-QulC) in 2010. Through TC-QulC, multidisciplinary teams from hospitals, nursing homes, rehabilitation centers, home care agencies, and a hospice collaborate on efforts to work more effectively with family caregivers to create smoother and safer transitions between health care settings. The first round of TC-QulC ended in 2011, with teams reporting significant progress using qualitative and quantitative measures. Plans are proceeding to launch a second round of the learning collaborative, with many first-round participants returning and other new ones joining.

Active partnerships between hospitals, nursing home rehabilitation programs, home care agencies, and hospices—as well as a robust educational component—are the keys to the success of Next Steps in Care. Monthly webinars, four all-day Learning Sessions, and regular coaching and consulting help engage the staff of partnering organizations in the program. Family caregivers undergo a self-assessment to identify their concerns and gauge their ability to provide the required care, either alone or with help. This assessment is built into the care plan.

The United Hospital Fund has learned several key lessons during implementation of the Next Steps in Care program:

- **Identify family caregivers.** Hospitals need a systematic way to identify family caregivers, record the caregiver in the patient chart, and understand the caregiver's role in caring for the patient. Hospital staff must recognize that the person who picks up the patient at the hospital is not necessarily the one who will provide the care.
- **Foster trust and communication between caregiver and staff.** Staff must understand the caregiver's needs and wants.
- **Be consistent and inclusive.** Just because staff members work at the same institution or fulfill similar roles does not mean they have the same understanding of the discharge process. That's why consistent education about that process is essential. In addition, make sure that any improvements in the process work for staff on all shifts and in different care settings.
- **Align goals.** It's important to recognize that the goal of reducing readmissions may compete with the goal of reducing length of stay.
- **Change staff behaviors and attitudes.** Deploying technology or creating better forms is no substitute for changing staff behavior and attitudes.
- **Track readmissions.** Tracking hospital admissions was not an initial goal of the Next Steps in Care Program. However, a few sites implemented such tracking and were able to document a reduction in hospitalizations. This component will be added to the program during its second round.

Implementation of Transitional Care Model at VNSNY CHOICE

The VNSNY CHOICE Health plans offer three Medicare Advantage plans and two Long Term Care plans, including one specialized plan called VNSNY CHOICE Total, which combines the benefits of a Medicaid plan with the benefits of a Medicare Advantage plan.

Through a joint collaborative, VNSNY CHOICE developed protocols for transitional care that includes but is not limited to home visits by nurse practitioners who provide medication reconciliation and other best practices to avoid an acute rehospitalization. VNSNY CHOICE experienced both challenges and successes in four areas:

1. **Human:** The program had challenges with delays in communicating between team members due to staff changes, increasing staff, sharing information, and providing the necessary services at the right time, such as palliative care. In contrast, its successes have included satisfaction among physicians, enhanced interdisciplinary communication, and effective training and support of Medicaid Managed Long-Term Care and Medicare Advantage staff. However, the single most important success has been regular check-in meetings that reinforces best practices and addresses weaknesses in the protocol that needs improvement.
2. **System design:** Program organizers designed a simple, real-time online referral system that features hubs that can be accessed by both management and operations staff in every borough of New York City. The system provides a seamless way to both transmit and process referrals. The online provider directory has been helpful for nurse practitioners who were previously unable to find a specialist or other provider.
3. **Weekend coverage:** There have been many gains with selecting members who are most appropriate for transitional care and presenting members on Medicare grand rounds. A recurring challenge of the program is it still needs weekend nurse practitioner coverage. Currently, all weekend calls and after hours go to a customer care call center.
4. **Nurse practitioners:** Gathering hospital clinical information has been an ongoing challenge especially in hospitals that do not value the collaborative benefit of transitional care. Another challenge for the program has been leveraging the prescriptive authority of nurse practitioners where the primary care responsibility lies with the physician of record. Providing transitional care within a 30-day episode is also very challenging especially in cases where palliative care is needed.

CHAPTER 4: CONCLUSION

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Health care is at a critical fork in the road. At this fork, providers and policy makers alike must ask two critical questions:

- Do we continue down a path that frustrates clinicians, confuses patients, and doesn't consistently align incentives with improving value or quality?
- Or, do we align quality and value efforts with care where it matters, at the frontline with clinicians and patients?

It should come as no surprise that the Agency for Healthcare Research and Quality (AHRQ) favors the second option. AHRQ has been instrumental in developing tools to help health care providers improve their quality of care and their understanding of the patient experience of care. Many of these tools specifically address the issue of care transitions. These include measurement tools, tools to assist in the discharge process through the use of avatars, and a hospital readmission reduction program.

How will we measure our success? Not by preventing all hospital readmissions. After all, not all readmissions are unnecessary; some should be celebrated while other should be prevented. We also can't measure our success by our ability to avoid readmissions within the arbitrary 30-day cutoff on which most tools focus.

Success will only be reached when we establish care transition systems that serve patients well by taking a team approach, collecting only necessary data, and applying the latest learning to the work environment.

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