

HealthAffairs

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# Health Policy Brief

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## Improving Care Transitions. Better coordination of patient transfers among care sites and the community could save money and improve the quality of care.

### WHAT'S THE ISSUE?

The term *care transition* describes a continuous process in which a patient's care shifts from being provided in one setting of care to another, such as from a hospital to a patient's home or to a skilled nursing facility and sometimes back to the hospital. Poorly managed transitions can diminish health and increase costs. Researchers have estimated that inadequate care coordination, including inadequate management of care transitions, was responsible for \$25 to \$45 billion in wasteful spending in 2011 through avoidable complications and unnecessary hospital readmissions.

Several new federal initiatives aim to encourage more effective care transitions. In addition, debate continues over how to restructure fee-for-service payments to motivate providers across care settings to work as a team to make transitions smoother.

This brief examines the factors contributing to poor care transitions, describes the elements of effective approaches to improving patient and family experience with transitions, and explores policy issues surrounding payment reforms designed to address the problem.

### WHAT'S THE BACKGROUND?

For years, health policy experts have identified poor care transitions as a major contributor to poor quality and waste. The 2001

Institute of Medicine (IOM) report, *Crossing the Quality Chasm*, described the US system as decentralized, complicated, and poorly organized, specifically noting "layers of processes and handoffs that patients and families find bewildering and clinicians view as wasteful."

The IOM noted that, upon leaving one setting for another, patients receive little information on how to care for themselves, when to resume activities, what medication side effects to look out for, and how to get answers to questions. As a result, the conditions of many patients worsen and they may end up being readmitted to the hospital. For example, nearly one-fifth of fee-for-service Medicare beneficiaries discharged from the hospital are readmitted within 30 days; three-quarters of these readmissions—costing an estimated \$12 billion a year—are considered potentially preventable, especially with improved care transitions.

**ROOT CAUSES:** There are several root causes of poor care coordination. Differences in computer systems often make it difficult to transmit medical records between hospitals and physician practices. In addition, hospitals face few consequences for failing to send medical records to patients' outpatient physicians upon discharge. As a result, physicians often do not know when their patients have been released and need follow-up care. Finally, current payment policies create disincentives for hospitals to invest in smoother care transitions. For example, although Medicare does

# \$12 billion

## Preventable readmission costs

Potentially preventable 30-day hospital readmissions cost Medicare about \$12 billion annually.

not allow hospitals to bill for readmissions that occur within 24 hours of discharge, it does pay full price for most readmissions that occur after that time. This means that the prevailing financial incentive for hospitals is to not expend resources on improving care transitions because a poor transition often leads to readmission, which generates additional revenue.

Moreover, some analysts believe that Medicare and Medicaid payment policies have unintentionally created incentives to unnecessarily transfer patients back and forth between hospitals and nursing homes. Their suspicion is that nursing homes, which are primarily paid by Medicaid with generally low payment rates, unnecessarily transfer patients to hospitals to qualify for more generous Medicare payment rates when their patients return to them after discharge.

Lending credence to this claim, researchers have found that states with lower rates of Medicaid spending on dual-eligible patients under age 65 (people who are eligible for both Medicaid and Medicare) have higher rates of Medicare spending on these patients, and vice versa, suggesting that providers are “gaming” the system.

**TRANSITION TO PRIMARY CARE:** As mentioned, one of the biggest barriers to smoother care transitions is the fact that primary care physicians often have little or no information about their patients’ hospitalizations. A review of the literature published in the *Journal of the American Medical Association* in 2007 found that physicians had received a hospital discharge summary about their patients, and had it on hand, in only 12–34 percent of first postdischarge visits. Even when discharge summaries are received, they often lack key information, such as test results, treatment course, discharge medications, and follow-up plans. The situation is even worse for those patients who have no usual source of care.

Patients often don’t consistently receive follow-up care after leaving the hospital. Among Medicare beneficiaries readmitted to the hospital within 30 days of a discharge, half have no contact with a physician between their first hospitalization and their readmission. (Exhibit 1 shows 30-day hospital readmissions under Medicare as a percentage of admissions, by state.)

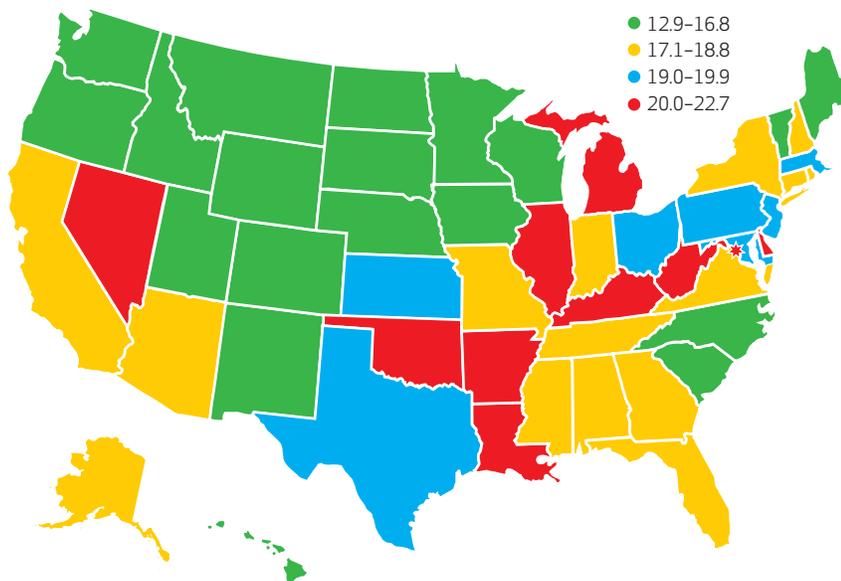
This problem may be worsening because of an ongoing shift in practice patterns. Increasingly, outpatient primary care physicians are no longer visiting their patients when hospitalized, and hospitalized patients’ care is now being managed by “hospitalists”—physicians who only treat patients in the hospital. Although hospitalists are generally believed to have improved the quality and coordination of patients’ in-hospital care, their presence, and the removal of patients’ outpatient primary care physicians from the hospital, has led to an increased need for care coordination among providers that doesn’t always occur.

**CARE TRANSITION MODELS:** Several models for improving transitions after hospitalization have been developed and rigorously tested. One of the most widely disseminated is the Care Transitions Intervention developed by Eric Coleman at the University of Colorado. This approach involves “transitions coaches,” primarily nurses and social workers, who first meet patients in the hospital and then follow up through home visits and phone calls over a four-week period.

The coaches promote development of patients’ skills in four key self-care areas: managing medications; scheduling and preparing for follow-up care; recognizing and responding to “red flags” that could indicate a worsening condition, such as the onset of a fever

### EXHIBIT 1

#### Medicare 30-Day Hospital Readmissions as a Percentage of Admissions, 2009



**SOURCE** Commonwealth Fund, “Medicare 30-Day Hospital Readmissions as a Percent of Admissions: National Metrics,” October 2009.

# 30%

## Reduction in readmissions

A care transitions intervention reduced 30-day hospital readmissions by 30 percent in a large integrated delivery system in Colorado.

**“Poorly managed transitions can diminish health and increase costs.”**

or worsening breathing problems; and taking ownership of a core set of personal health information by having patients brainstorm and ask their providers questions about their conditions or self-care routine. In a large integrated delivery system in Colorado, the Care Transitions Intervention reduced 30-day hospital readmissions by 30 percent, reduced 180-day hospital readmissions by 17 percent, and cut average costs per patient by nearly 20 percent. The intervention has been adopted by more than 700 organizations nationwide.

Another rigorously tested transitional care model, developed by Mary Naylor and her colleagues at the University of Pennsylvania, involves a longer period of intervention targeted at a high-risk, high-cost subset of elderly patients, such as those hospitalized for heart failure. In six academic and community hospitals in Philadelphia, this approach reduced readmissions by 36 percent and costs by 39 percent per patient (nearly \$5,000) during the 12 months following hospitalization. Under the Naylor model, an advanced practice nurse not only coaches patients and their caregivers to better manage their care but also coordinates a follow-up care plan with patients’ physicians and provides regular home visits with seven-day-a-week telephone availability.

## WHAT’S IN THE LAW?

The Affordable Care Act contains several provisions that could improve care transitions. These include both “carrots” (financial incentives) and “sticks” (financial penalties).

Among the carrot approaches, starting October 1, 2012, hospitals can receive increases to their Medicare payments if they achieve or exceed performance targets for certain quality measures, including whether they told patients about symptoms or problems to look out for postdischarge; whether they asked patients if they would have the help they needed at home; and whether they provided heart failure patients with discharge instructions. (See the [Health Policy Brief](#) published on April 15, 2011, for more information on improving quality and safety.)

Among the stick approaches, also beginning October 1, 2012, the Centers for Medicare and Medicaid Services (CMS) can reduce payments by 1 percent to hospitals whose readmission rates for patients with heart failure, acute myocardial infarction, or pneumonia exceed a particular target. According to a recent analysis by the Kaiser Family Foundation, more

than 2,200 hospitals will forfeit about \$280 million in Medicare payments over the next year because of these readmissions penalties.

**MEDICAL HOMES:** The law also authorizes paying providers for care transition services as part of payments to primary care practices that operate as “medical homes”—practices that closely manage and coordinate the care of patients with chronic conditions. One demonstration project, which predates the Affordable Care Act, is the Multi-Payer Advanced Primary Care Practice Demonstration in which Medicare offers practices that have been formally recognized as medical homes in eight states up to \$10 per beneficiary per month to cover the cost of medical home services, which include care transition planning.

Another demonstration, the Comprehensive Primary Care Initiative, offers monthly payments to practices that average \$20 per beneficiary in the first two years and then transitions to \$15 plus the opportunity to earn shared savings in the last two years. Again, a portion of these programs are intended to compensate practices for the costs of care coordination and care transitions planning.

In addition, the Federally Qualified Health Center Advanced Primary Care Practice Demonstration will pay \$6 per beneficiary per month to health centers that adopt the medical home model and apply for Level 3 medical home recognition, having the most stringent requirements, from the National Committee for Quality Assurance (NCQA) by the end of the three-year demonstration. NCQA’s medical home standards ask practices to establish processes to identify patients admitted to the hospital; share clinical information with the admitting hospital; obtain patient discharge summaries from the hospital; and contact patients for follow-up care, among many other expectations.

**MEDICAID AND MEDICARE:** State Medicaid agencies can now offer providers enhanced reimbursement, such as through monthly care management payments, to cover the cost of “comprehensive transitional care” and other services if the practice qualifies as a “health home”—a practice that cares not only for Medicaid patients’ physical conditions but also helps them obtain such other services as behavioral health care and long-term care services and supports.

Also, a five-year, \$500 million Community-Based Care Transitions Program pays organi-

# 39%

## Reduction in patient costs

A care transitions intervention reduced readmission costs by 39 percent per patient in six hospitals in Philadelphia.

**“The prevailing financial incentive for hospitals is to not expend resources on improving care transitions.”**

zations that partner with hospitals with high readmission rates to provide care transition services for high-risk Medicare beneficiaries. All-inclusive payments cover the cost of care transition services provided to individual beneficiaries in the 180 days following an eligible discharge plus the cost of systemic changes made by partner hospitals to improve care transitions. So far 47 awardees have been announced, and applications continue to be accepted. Participating organizations initially enter into two-year agreements, which can be extended annually through the end of 2015.

**INCENTIVES IN NEW PAYMENT MODELS:** The Medicare Shared Savings Program for accountable care organizations (ACOs) will give groups of providers an incentive to coordinate care more closely to keep patients healthy and out of the hospital because they will be eligible to share in the savings they are able to generate relative to a spending benchmark. The quality metrics that must be met by accountable care organizations to benefit financially under the program include six that pertain to care coordination, including preventing unnecessary hospital readmissions. (See [Health Policy Brief](#) published on January 31, 2012, for more information on ACOs.)

The Affordable Care Act also authorizes five-year bundled payment pilots in Medicare and Medicaid to test whether making a single payment to one entity for services provided by several providers for an episode of care, such as a knee replacement, will give providers an incentive to work together to ensure that patients receive all the services they need, including hospital and follow-up care, in a more efficient manner. Managing care transitions to prevent costly hospital readmissions will be particularly important because—in the Medicare pilot, at least—the bundled payment will cover services beginning three days before a hospital admission for an eligible condition and extending 30 days after hospital discharge.

Signaling the importance of care transitions to the success of these efforts, the Medicare pilot requires bundled payments to cover the cost of “transitional care services.” CMS’s new Innovation Center has begun accepting applications from providers interested in piloting four bundled payment models through a separate Bundled Payments for Care Improvement initiative. The Medicaid pilot, meanwhile, requires participating hospitals to have “robust discharge planning programs.”

In addition, a new Medicare-Medicaid Coordination Office in CMS is charged with better integrating benefits for dual-eligible beneficiaries. It also works to ensure “safe and effective care transitions,” among other goals. This office has awarded contracts of up to \$1 million each to 15 states to design models to coordinate primary, acute, behavioral, and long-term care for Medicare-Medicaid enrollees. CMS has also invited proposals from states to test two new payment models to better integrate care for this population and allow states to share in savings from these improvements. Twenty-six states, including the 15 states awarded demonstration design contracts, have developed proposals for this demonstration. The new payment and delivery system models are likely to focus on improving care transitions, among other strategies. (See the [Health Policy Brief](#) published on June 13, 2012, for more information on dual eligibles.)

**PHYSICIANS AND NURSES:** The Affordable Care Act also requires the Department of Health and Human Services to develop and implement a plan by 2013 that would lead to reporting physician-level quality measure data on the new [Physician Compare](#) website, including measures of the quality of care transitions. CMS has until 2019 to decide whether to conduct a demonstration giving Medicare beneficiaries financial incentives to seek care from physicians who score highly on these measures.

The law also creates a \$200 million, four-year workforce development demonstration aimed at increasing the number of advanced practice registered nurses trained in care transition services, chronic care management, preventive care, primary care, and other services appropriate for Medicare beneficiaries.

**MIXED MESSAGES:** Taken as a whole, the inclusion in the Affordable Care Act of these carrots and sticks aimed at different types of providers suggests a tension over whom to pay and how to pay them to improve care transitions. On the one hand, the payment cuts that high-readmission hospitals nationwide will soon face create an expectation that hospitals take responsibility for improving care transitions using existing resources. But the fact that another program will provide new care transitions payments to hospitals and community-based organizations suggests that they may require additional resources to provide these services.

# 1%

## Hospital payment penalty

Starting October 1, 2012, the Centers for Medicare and Medicaid Services can reduce payments by 1 percent to hospitals whose readmission rates for patients with certain conditions exceed a particular target.

**“Primary care physicians often have little or no information about their patients’ hospitalizations.”**

And although physicians’ performance on care transitions quality measures will be reported on [Physician Compare](#), no provision in the Affordable Care Act requires hospitals to alert physicians when their patients are discharged, typically the needed first step before a physician can become involved in a care transition.

## OTHER POLICY OPTIONS

If these Affordable Care Act provisions fail to improve care transitions or if CMS decides to pursue other policies, the agency’s statutory authority gives it some additional options, as follows:

- **Pay physicians for care transition services.** Under the Medicare physician fee schedule, CMS could create a new billing code that would enable physicians to bill for delivery of care transition services. In a proposed rule issued in July 2012, CMS would create a code to bill for care transition services delivered to Medicare beneficiaries in the 30 days following a discharge from a hospital, skilled nursing facility, or community mental health center. The code would apply to Medicare patients whose medical or psychosocial problems, or both, require moderate- or high-complexity medical decision making.

To qualify for the new payment, physicians would have to obtain and review a patient’s hospital discharge summary, update the patient’s medical records to reflect changes in health conditions and ongoing treatments, and establish or adjust a patient’s care plan. Physicians would be required to communicate with a beneficiary or their caregiver within two business days of discharge to resolve medication discrepancies and inform them about possible complications. Whether physicians will consider the payment level assigned to this billing code adequate for the effort required, however, remains unclear.

- **Track whether hospitals transmit records to physicians.** Another policy option would be to add a care transitions measure to Medicare’s Hospital Inpatient Quality Reporting program, a pay-for-reporting program. Adding such a measure would create a modest incentive for hospitals to better communicate with physicians about patients’ hospitalizations, especially if CMS chose to include that measure in the subset that is displayed on the [Hospital Compare](#) website.

If CMS wanted to further elevate hospitals’ focus on this measure, it could include it in the subset of measures it uses in the Hospital Value-Based Purchasing Program, the new pay-for-performance program for hospitals created in the Affordable Care Act and scheduled to go into effect in October 2012.

A hospital-related care transitions measure has been developed by a group of physician specialty societies and endorsed by the National Quality Forum, a nonprofit organization that works with providers, consumer groups, and governments to establish and build consensus for specific health care quality and efficiency measures. This indicator, called “Timely Transmission of Transition Record” (measure no. 0648), measures how often a hospital sends a transition record to a patient’s physician within 24 hours of discharge. Having this information would allow primary care physicians to identify which patients needed follow-up care.

However, hospitals may not welcome this additional reporting burden because transmittal of such records to outpatient physicians is not a billable hospital service, which means claims data cannot be used to easily calculate how often such transmittals occur. Instead, for hospitals that don’t have good electronic health record systems, labor-intensive chart reviews would be required to calculate such a measure.

If CMS were to pay hospitals to develop discharge plans, discuss them with patients, and transmit them to outpatient physicians for follow-up care, the hospitals would have a greater incentive to perform these crucial activities. CMS could also then use the hospitals’ billing records for these services to calculate quality measures assessing how often the hospitals performed these important services.

However, in the current strained federal fiscal environment, offering a new carrot to hospitals may have little appeal for policy makers. Indeed, because Medicare already gives hospitals lump-sum payments to cover all the costs associated with a hospitalization and because Medicare’s conditions of participation require hospitals to have a discharge planning process in place, policy makers may feel hospitals are already being paid for care transition services but are simply not performing them as routinely as they should be.

- **Strengthen hospital do-not-pay policies.** Another policy stick would be to further

limit payment for hospital readmissions. For example, CMS could extend its current policy of not paying for Medicare readmissions that occur within 24 hours of a hospital discharge for the same condition to 72 hours, or even 15 or 30 days, postdischarge. Doing so would require carefully defining which readmissions would be ineligible for payments and how to account for co-occurring conditions. Already, hospitals as a group are upset about CMS's decision to penalize them for certain planned readmissions because they don't think it adequately distinguishes between readmissions that are truly necessary compared to readmissions that are truly preventable.

hospital readmissions, interest in improving care transitions to reduce Medicare spending is likely only to grow.

Although some care transitions interventions have generated cost savings, uncertainty remains over how best to encourage providers to use these approaches. Evaluation of the changes brought about by the Affordable Care Act will begin filling gaps in our knowledge. And if the health care law's approaches fail to make a strong enough case for providers to pay attention to care transitions, policy makers may want to explore bigger carrots and sticks. ■

### WHAT'S NEXT?

Given the current budgetary environment and the fact that Medicare is estimated to spend \$12 billion per year on potentially preventable

#### About Health Policy Briefs

Written by  
**Rachel Burton**  
Research Associate  
Urban Institute

Editorial review by  
**Eric Coleman**  
Division Head  
Health Care Policy and Research  
University of Colorado Medical  
Campus

**Debra J. Lipson**  
Senior Researcher  
Mathematica Policy Research

**Ted Agres**  
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### RESOURCES

Bubolz, Thomas, Constance Emerson, and Jonathan Skinner, "[State Spending on Dual Eligibles under Age 65 Shows Variations, Evidence of Cost Shifting from Medicaid to Medicare](#)," *Health Affairs* 31, no. 5 (2012): 939–47.

Coleman, Eric A., "[Falling through the Cracks: Challenges and Opportunities for Improving Transitional Care for Persons with Continuous Complex Care Needs](#)," *Journal of the American Geriatrics Society* 51, no. 4 (2003): 549–55.

Hackbarth, Glenn, "[Report to the Congress: Promoting Greater Efficiency in Medicare](#)," Medicare Payment Advisory Commission, June 2007.

Kripalani, Sunil, Frank LeFevre, Christopher O. Phillips, Mark V. Williams, Preetha Basaviah, and David W. Baker, "[Deficits in Communication and Information Transfer between Hospital-Based and Primary Care Physicians](#)," *JAMA* 297, no. 8 (2007): 831–41.

Kronick, Richard, and Todd P. Gilmer, "[Medicare and Medicaid Spending Variations Are Strongly Linked within Hospital Regions but Not at Overall State Level](#)," *Health Affairs* 31, no. 5 (2012): 948–55.

Naylor, Mary D., Linda H. Aiken, Ellen T. Kurtzman, Danielle M. Olds, and Karen B. Hirschman, "[The Importance of Transitional Care in Achieving Health Reform](#)," *Health Affairs* 30, no. 4 (2011): 746–54.

Pham, Hoangmai H., Joy M. Grossman, Genna Cohen, and Thomas Bodenheimer, "[Hospitalists and Care Transitions: The Divorce of Inpatient and Outpatient Care](#)," *Health Affairs* 27, no. 5 (2008): 1315–27.

Tilson, Sibyl, and Geoffrey J. Hoffman, "[Addressing Medicare Hospital Readmissions](#)," Congressional Research Service, May 25, 2012.