

















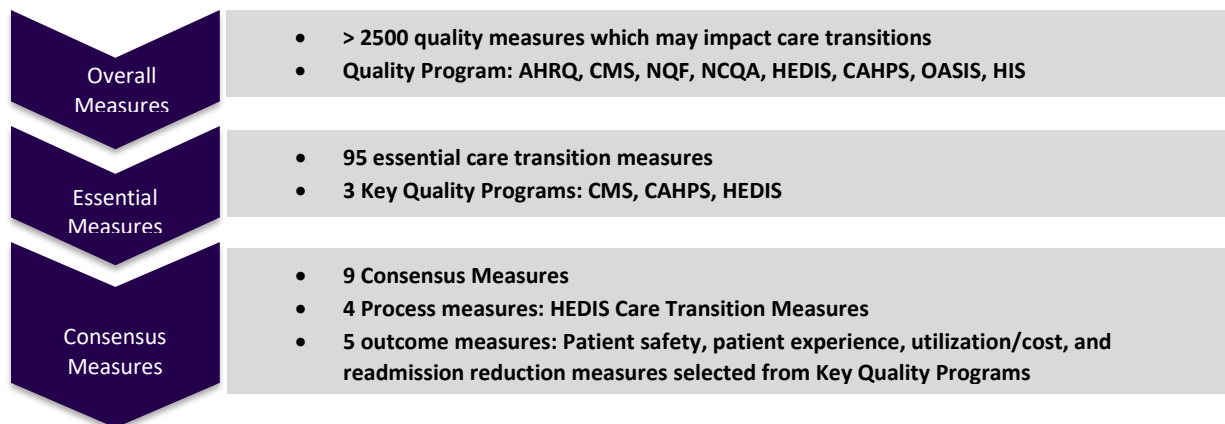




## Metrics

There are currently more than 2500 different quality measures that impact transitions of care. These are associated with a variety of quality programs and are often specific to practice settings (acute care, payer, ambulatory, skilled nursing facility, home health, hospice and other sites of services). This contributes to and maintains a silo approach to care transitions and hinders overall alignment across settings. Aligned measurement is essential to meaningful assessment of gaps and opportunities for efficient care coordination. To assist those organizations implementing the ACMA TOC standards in developing an evaluation approach, the Executive Steering Committee reviewed existing care transition measures, identified a larger set of essential measures and smaller set of consensus measures.

## Our Approach



The consensus measures presented within this document are intended to guide evaluation efforts of the effectiveness of the implementation of the ACMA TOC Standards. The consensus measures have been distilled from government, payer and other quality programs, and have been endorsed by the Executive Steering Committee as the most meaningful measures to evaluate the implementation of the standards. Process measures are intended to evaluate performance in implementing the standards, and outcome measures are intended to assess the impact implementing the standards has on quality, utilization, patient satisfaction and cost of care. An overview and further discussion are found in the Metrics Alignment Resource in this document.

## Evaluation and Ongoing Assessment of the Transition Standards

Mechanisms must be in place to measure and periodically assess transitional care outcomes. Established quality improvement processes for tracking and measurement of key utilization metrics are essential. All settings must assure that meaningful process, outcome and patient experience metrics are used to evaluate and continuously improve performance. ACMA will conduct demonstration projects utilizing a proven Pfizer tool, The Health Outcomes Program Evaluation (HOPE) to gather initial evaluation data. Findings and outcomes from these pilot sites will provide a framework and benchmarks for ongoing refinement.

Case management and transitions of care professionals directly responsible for care coordination can take the lead in driving cost, effectiveness, and efficiency for care transitions by adopting these common standards across care settings. Several of the organizations represented on the Executive Steering Committee have agreed to implement and evaluate the standards as part of an overall quality improvement initiative. The evaluation will include an analysis of performance on key metrics presented in the Metrics section of this report. The full analytic plan is under development and will be approved by the steering committee.

## Tools

Additional tools and resources will soon be available on the ACMA website under Transitions of Care. This dynamic repository will house a compilation of tools and resources to support work in longitudinal care management.

# PERSPECTIVES

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## ***Home health & hospice perspective | Andrea Devoti, Executive Vice President, National Association of Home Health & Hospice***

“At no other time has the sharing of information and communication of findings been more critical than it is now. We have the ability to provide the best care to our citizens if we will break down the walls between us and share appropriate data and knowledge.”

## ***SNF | Post-acute case management | Janeen Forman, Corporate Director, Case Management, LifeCare (Management Service)***

“With the increased number of chronic, critically-ill patients, structures need to be developed to facilitate transitions across the continuum of care.

The structure the ACMA standards provide will improve patient handoffs and promote greater patient satisfaction, while reducing redundancy, decreasing subsequent hospitalization and maintaining quality of care.”

## ***Acute Care | Dale Beatty, Chief Nursing Executive & Vice President, Stanford Health***

“I think it is so important that we set our standards based on a shared vision, mission, and desired outcomes rather than a structure that is budget neutral.

Case management has progressed from the days of nursing discharge as the key purpose and single driver. Back then, if the only consideration was to be thinking budget neutral...we would not have progressed to where we are today. Adopting the Standards will support and optimize care coordination models needed under value-based care.

We should be bold in setting our standards. Each organization’s profile, volume, and acuity will vary, so structure may vary as well, but the standards should be the North Star.”

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# STANDARDS

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# STANDARD 1.0 Identify Patients at Risk for Poor Transitions

Processes are in place to identify individuals at risk for poor transitions so that appropriate measures can be taken by care team members at any location on the continuum to ensure optimum patient health outcomes.

Healthcare entities can meet this standard through evidence of the following essential health risk identification elements:

Use of a validated **health risk assessment tool** that meets regulatory requirements for the care delivery setting and assigns a quantifiable risk score that can be measured.

Communication of health risk assessment findings to known **episodic care managers** across the care continuum.

Reassessment at each episode of care or transition to a new care setting for those identified as at-risk.

Implementation of performance improvement processes to identify root causes for failed transition or readmission.

Screening for medical, behavioral and social factors associated with high risk for poor transitions, including **social determinants of health**.

- Frequent facility admissions and/or inappropriate utilization of health-care resources
- Polypharmacy and/or poor medication adherence
- Multiple co-morbidities and/or 2+ chronic conditions
- Cognitive or functional impairments
- Behavioral Health Issues
- Social determinants

Incorporation of proactive predictive-risk modeling of specific patient populations through the analysis of internal and external information, such as state, community, institutional or payer data sets.

Optimization of available technologies to deliver the services associated with the standard.

## ROLES

Unlicensed personnel, based on the care setting, may complete the performance and documentation of the health risk assessment. This differs from the clinical assessment, which *must* be performed by licensed/credentialed professionals.

**Health Risk Assessment Tool** - A health risk assessment (HRA) is a survey or questionnaire used to collect relevant information about the health status and health risk factors of an individual or population.

**Episodic Care Manager** - The person at a specific level of care who provides care management for the patient in that setting.

**Social Determinants of Health** – as defined by the World Health Organization (WHO), are the conditions in which people are born, grow, live, work and age. These conditions may include: financial or economic limitations, poor health literacy, housing/food instability, lack of social support, unreliable transportation, and unhealthy behaviors. The circumstances are shaped by the distribution of money, power and resources at global, national and local levels.

# STANDARD 2.0 Complete a Comprehensive Transition Assessment

Processes are in place to conduct a comprehensive transition assessment for patients identified as high-risk for poor transitions across care settings. Attention is given to further identify patients who may become at risk in the new setting.

Organizations can meet this standard by showing evidence that a comprehensive transition assessment is completed, and that the following elements are included:

Review of relevant healthcare utilization across all care settings including recent provider orders, payer benefits, preferred networks, and claims data when available.

Solicit patient, family and caregiver goals for care and potential transitions for settings and levels of care.

Evaluate and document patient/family/caregiver engagement and understanding of current health status.

**Assess self-management abilities, which may include** activities of daily living (ADL), **instrumental activities of daily living** (IADL), patient's decision-making ability and/or willingness to participate in care planning discussions.

Review of **social determinants of health**.

Completion of a medication reconciliation, and review of patient's medication adherence.

Review and documentation of patient care goals according to the regulations that govern the care setting and, when appropriate, identify the patient's **designated decision maker**.

Examination of **advance care planning documents** ensuring they are current, complete and available to the healthcare team.

Communication of assessment summary to next care setting.

## ROLES

Acute care: RN, LCSW, MSW

Ambulatory care: RN, LCSW, MSW, MD, APC  
(MA may collect data but may not assess)

Skilled nursing facility: RN, LCSW, MSW

Home Health: RN, LCSW, MSW, APC

Hospice: RN, LCSW, MSW, APC

Health plans/ACO: RN, LPN, LCSW, MSW, MD, PharmD

**Self-Management Ability** – Refers to a patient's ability to recognize symptoms and warning signs, identify the actions to take, know why medications have been prescribed and how to take them.

**Social Determinants of Health** – as defined by the World Health Organization (WHO), are the conditions in which people are born, grow, live, work and age. These conditions may include: financial or economic limitations, poor health literacy, housing/food instability, lack of social support, unreliable transportation, and unhealthy behaviors. The circumstances are shaped by the distribution of money, power and resources at global, national and local levels.

**Designated Decision Maker** – The family member(s), lay caregiver, surrogate or advocate who is authorized to make health care and other decisions for the patient.

**Advance Care Planning documents** – Documents include advance directives, living wills or Power of Attorney (POA).

**Instrumental Activities of Daily Living** - the activities often performed by a person who is living independently in a community setting during the course of a normal day, such as managing money, shopping, telephone use, travel in community, housekeeping, preparing meals, and taking medications correctly.<sup>2</sup>

<sup>2</sup> Mosby's Medical Dictionary, 9th edition. © 2009, Elsevier

# STANDARD 3.0 Perform and Communicate a Medication Reconciliation

Processes are in place to support a reconciled medication list at each care transition point.

**Organizations can meet this standard by showing evidence that a comprehensive transition assessment is completed, and that the following elements are included:**

Compilation of a full medication history, including both prescribed and non-prescribed medications, from all available sources, including:

- ✓ EHR and discharge summary
- ✓ E-prescribing records
- ✓ claims data
- ✓ paper records from other sites of care and providers
- ✓ self-reported from patient or caregiver
- ✓ patient's pharmacy
- ✓ regular **ambulatory care provider**

Identification of patients who may be at high-risk for medication related adverse events or non-adherence due to polypharmacy, opioids, high-cost / specialty drugs.

Review of medication history against active medications in the current setting.

Verification of medication list accuracy with patient or caregiver.

Verification of medication adherence with patient or caregiver, and assessment and documentation of any adherence and access barriers, including coverage, affordability, or transportation.

Document all medication reconciliation activities in the medical record, using applicable coding.

## ROLES

The treating provider (MD, DO) involved at the time of transition must be the party who is accountable for the reconciliation. The medication review may be performed by a designated clinical team member. The clinical pharmacist is uniquely qualified to make recommendations to optimize medication therapy and avoid potential adverse events such as drug-drug interactions.

Non-licensed providers **may gather** information but should neither perform medication reconciliation nor provide clinical recommendations.

**Ambulatory Care Provider:** The care provider who provides regular ambulatory care to a patient outside of an acute or institutional setting. This may be a PCP, ACP or other licensed healthcare provider appropriate to the setting.

# STANDARD 4.0 Establish a dynamic care management plan that addresses all settings throughout the continuum of care.

Processes are in place to support the development of an ongoing care management plan, created with input from the patient, primary caregiver, and family. This care plan should be accessible to all care managers and remain with the patient's regular **ambulatory care provider** for continuity.

## Organizations can meet this standard by demonstrating that the care management plan includes the following elements:

Review of all available data, including information gathered from patient self-report or from individuals within the patient's support network.

Review of goals for care and potential transitions for settings and levels of care with patient/family/caregiver.

Tracking methodology for high-risk patients with an ongoing care management plan.

Identification and documentation of:

- regular ambulatory care provider
- health plan benefits and known barriers
- designated caregivers
- pharmacy/pharmacies used
- specialty care providers
- home health/home care provider
- social service agencies
- known episodic or longitudinal care manager

Identification and documentation of **advance care planning documents**.

Pharmacy consult as appropriate, with documentation of the outcome and evidence of patient/family/caregiver awareness and understanding of the necessary course of action.

Evidence of timely reassessments as the patient moves across care settings.

Documentation of referrals and linkages to community resources and services.

Documentation of patient and support network agreement to referrals and linkages.

Supporting documentation that services and referrals meet the expectations and requirements of payers.

Utilization of available technologies to maximize accuracy with the ability to efficiently transfer care plan information across the care continuum (patient, caregiver, provider, and longitudinal/episodic care managers), using secure data exchanges and paperless systems when possible.

Identification and documentation of **episodic or longitudinal care managers** coordinating transitions across the care continuum.

Communication and sharing of the care plan to known episodic or longitudinal care managers across the care continuum.

Whenever possible, the care management plan is shared through secure data exchanges to create a paperless system of care planning across the care continuum.

## ROLES

Roles vary by care settings but the following personnel may be involved in the development of an ongoing care management plan.

**Acute care:** RN, LCSW, MSW, MD, APC, PharmD

**Ambulatory care:** PCP, RN, APC, LCSW, MSW, Practice manager, PharmD

**Skilled nursing facility:** RN, MDS coordinator, LCSW, MSW, administrator, APC, PharmD

**Home Health:** RN, LCSW, MSW, APC, PharmD

**Hospice:** RN, LCSW, MSW, APC, PharmD, APC

**Health plans/ACO:** RN, LCSW, MSW, LPN, PharmD

**Ambulatory Care Provider:** The care provider who provides regular ambulatory care to a patient outside of an acute or institutional setting. This may be a primary care physician (PCP), an advanced practice clinician (APC) or other licensed healthcare provider appropriate to the setting.

**Advance Care Planning documents** – Documents include advance directives, living wills or Power of Attorney (POA).

**Episodic Care Manager:** The person at a specific level of care who will be the care manager for the patient in that setting. This may be care coordination personnel from within the payer, primary care, ambulatory care or social service agency setting as well as traditional acute or institutional settings.

**Longitudinal Care Manager:** A strategy which ensures the understanding of care delivered across multiple settings and fosters relationships across the system of care. For example, this may occur in an Accountable Care Organization, Patient Centered Medical Home (PCMH) or payor group with high-risk patients.



# STANDARD 5.0 Communicate Essential Care Transition Information to Key Stakeholders Across the Continuum of Care

Processes are in place to ensure the timely transfer of essential TOC information to key stakeholders including the caregiver, the regular *ambulatory care provider*, the payer and the identified *episodic care manager* in the next care setting.

## Organizations can meet this standard by showing evidence that:

Appropriate TOC stakeholders are identified. These stakeholders may include: patient and caregivers, regular ambulatory care provider, pharmacists in all relevant settings, care manager at the next care setting, payer, and community service agencies.

A standardized, securely maintained framework for communication transfer is used.

Communications are deployed electronically whenever possible.

Information transfer includes an acknowledgement of receipt.

Essential transition information is communicated, including both clinical and **social determinants of health**. Clinical determinants should include, as appropriate:

- ✓ Diagnosis, co-morbidities, chronic condition
- ✓ Medications, known history of adherence
- ✓ Potential for polypharmacy, opioid or substance abuse
- ✓ Labs and other tests
- ✓ Appointments
- ✓ Cognitive or functional impairments
- ✓ Behavioral health issues

## ROLES

Roles vary by care setting but the following personnel may be involved in the development of an ongoing care management plan.

**Acute care:** RN, LCSW, MSW, APC, PharmD

**Ambulatory care:** MD, RN, LPN, LCSW, MSW, PharmD

**Emergency care:** RN, EMT, paramedic, PharmD

**Skilled nursing facility:** MD, APC, RN, LPN, LCSW, MSW, PharmD

**Home Health:** RN, LCSW, MSW, LPN, PharmD, APC

**Hospice:** RN, LCSW, MSW, LPN, PharmD, APC

**Health plans/ACO:** RN, LPN, LCSW, MSW, PharmD

Non-licensed staff may transfer information via fax or secure portal

**Ambulatory Care Provider:** The care provider who provides regular ambulatory care to a patient outside of an acute or institutional setting. This may be a PCP, APC or other licensed healthcare provider appropriate to the setting.

**Episodic Care Manager:** The person at a specific level of care who will be the care manager for the patient in that setting.

**Social Determinants of Health** – As defined by the World Health Organization (WHO), this term refers to conditions in which people are born, grow, live, work and age. These conditions may include: financial or economic limitations, poor health literacy, housing/food instability, lack of social support, unreliable transportation, and unhealthy behaviors. The circumstances are shaped by the distribution of money, power and resources at global, national and local levels.

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# APPENDIX A

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**Metrics used across healthcare settings that may be impacted with the implementation of the Transitions of Care Standards.**

# METRICS

## Overview & Organization

This metric alignment identifies the quality programs and associated metrics the Transitions of Care Standards are likely to impact from across a variety of healthcare settings. The purpose of this resource is to list *essential measures*, aligned to the evaluation measures and specific quality programs in place as of June 2018. While comprehensive, it does not cover all the setting-specific quality and outcomes measures that an organization may track.

The metrics identified here are aligned to each of the TOC standards and can support a common approach to data collection and benchmarking to measure related quality improvements. Additionally, a set of *consensus measures* is presented for each standard, representing those process and outcome evaluation metrics with the *broadest applicability* across settings of care. Consensus measures have been reviewed and endorsed by the ACMA Transition of Care Executive Steering Committee comprised of subject matter experts with a broad range of experience (See page 40).

## Selected Metrics

The metric alignment list of essential measures contains both care delivery and patient experience measures, which are found within the following six programs:

- AHRQ Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys
- CMS Hospital Inpatient and Hospital Outpatient Quality Reporting (IQR and OQR)
- CMS Medicare Part C and D Star Rating Program (STAR)
- CMS Medicare Shared Savings Program (MSSP)
- CMS Merit-Based Incentive Payment System (MIPS)
- NCQA Healthcare Effectiveness Data and Information Set (HEDIS)

## AHRQ Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

Developed by Agency for Healthcare Research and Quality (AHRQ), the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) patient experience surveys are a quality improvement tool for health care organizations that use standardized data to identify relative strengths and weaknesses, determine where they need to improve, and track progress over time. There are unique CAHPS surveys for over a dozen care settings and patient populations. Those listed here are the most broadly relevant but unique circumstances and settings might add other survey tools.

- **CAHPS Cancer Care Survey** assesses the cancer treatment experience in both inpatient and outpatient settings.
- **CAHPS Clinician & Group Survey** is used to collect experiences with health care providers and staff in doctors' offices as well as to equip consumers with information they can use to choose a physician or provider.
- **CAHPS Health Plan Survey** is now the national standard to collect enrollees' experience with health plans and their services, including the Department of Defense and Medicare plans.

- **CAHPS Home and Community-Based Services (HCBS)** is conducted in-person or by telephone to assess the experiences of those who receive long-term support and services from State HCBS programs.
- **CAHPS Home Health Care Survey** collects patient experiences with home health providers and agencies.
- **CAHPS Hospice Survey** is designed to assess the patient and caregiver experience of those patients who have died while receiving hospice care.
- **CAHPS Hospital Survey** (also referred to as HCAHPS) includes both an adult and a child survey for patients to report their inpatient experiences.
- **CAHPS Nursing Home Surveys** include three different surveys to collect experiences of Long-term residents (in-person survey), Discharged Residents (questionnaire) and Family Members of residents (questionnaire).
- **CAHPS Outpatient and Ambulatory Surgery Survey** collects experiences in both hospital outpatient surgery departments and ambulatory surgery centers.
- **CAHPS Surgical Care Survey** collects input on inpatient or outpatient experiences of pre-, during and post-surgery care to include the care, surgeons, staff and anesthesiologists as well as the post-operative follow-up care.

**Link**

<https://www.ahrq.gov/cahps/index.html> (accessed June 2, 2018)

### ***Centers of Medicare and Medicaid Services (CMS) Quality Metrics***

CMS has developed and implemented, under the direction of the US Congress, a variety of measures and care models with the purpose of providing financial incentives to providers to improve both the quality and the cost efficiency of care provided to Medicare and Medicaid patients. A variety of measures cover care settings and providers across the spectrum of healthcare delivery.

- **CMS Hospital Inpatient and Hospital Outpatient Quality Reporting Programs (IQR and OQR)** are quality reporting programs that provide financial incentive to hospitals treating Medicare patients to provide and report quality care as well as, through public reporting, provide Medicare patients with data to make informed choices about providers.

**Link**

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalOutpatientQualityReportingProgram.html> (accessed June 2, 2018)

- **CMS Medicare Shared Savings Program (MSSP)** establishes a voluntary alternate payment program that encourages groups of providers (doctors, hospitals and other providers) to create Accountable Care Organizations (ACOs). An ACO can improve beneficiary outcomes and increase value of care by providing: (1) Better care for individuals; (2) Better health for populations; and (3) Lowering growth in expenditures. The Shared Savings Program rewards ACOs that lower their growth in healthcare costs while meeting specific performance standards on quality of care and putting patients first.

**Link**

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/>

- **Merit-Based Incentive Payment System (MIPS)** is a payment program designed to reward value and outcomes in patient care. It is focused on individual eligible clinicians and group practices. The MIPS program combines the Physician Quality Reporting System, EHR Incentive Program, and Value-Based Payment Modifier into one unified program. Please note that the broader Quality Payment Program includes both MIPS and Alternative Payment Models (APMs). This is a new program, which will impact Medicare Fee-for-Service (FFS) provider payments in 2019 (with 2017 as the first performance period). Most of the care transition related measures listed are culled from the Improvement Activities performance category within MIPS, which assesses activities that improve clinical practice.

**Link**

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html>

- **CMS - Medicare Part C and D Star Rating Program** is a national pay-for-performance program focused on MA plans for Part C (without prescription drug coverage) and Part D (with prescription drug coverage). Ratings of quality and performance are determined on overall performance using information from member satisfaction, providers and plans.

**Link**

<https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html>

**Healthcare Effectiveness Data and Information Set (HEDIS)**

HEDIS is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS was designed to allow consumers to compare health plans to national and regional benchmarks. In 2018, HEDIS approved four care transition process metrics which the committee has endorsed as TOC Standard consensus process measures.

***Relevant Measure Sets Not Reflected in the Metric Alignment List***

**OASIS / Home Care**

The instrument/data collection tool used to collect and report performance data by home health agencies is called the Outcome and Assessment Information Set (OASIS). Since 1999, CMS has required Medicare-certified home health agencies to collect and transmit OASIS data for all adult patients whose care is reimbursed by Medicare and Medicaid with the exception of patients receiving pre- or postnatal services only. OASIS data are used for multiple purposes including calculating several types of quality reports which are provided to home health agencies to help guide quality and performance improvement efforts. OASIS-C2 is the current version of the OASIS data set. It was developed from OASIS-C1/ICD-10 in 2016.

**HIS / Hospice Item Set**

The HIS is a set of data elements that can be used to calculate seven quality measures. An item set is a standardized mechanism for abstracting data from the medical record.

**Discussion**

The Institute of Healthcare Improvement's (IHI) Quadruple Aim focuses on the simultaneous pursuit of improving the patient experience of care, clinical outcomes, the health of populations and reducing the per capita cost of healthcare. The pursuit of these goals provides a framework for high quality, efficient healthcare systems.

Consistent with Quadruple Aim, the measures identified in the metric alignment list include patient experience,

population health and cost related measures. Many of the measures identified in the table are endorsed by the National Quality Forum (NQF), which is considered the gold standard for healthcare measurement in the United States. The National Committee for Quality Assurance (NCQA) Health Effectiveness Data and Information Set (HEDIS), a set of performance measures widely used within the managed care industry, is also included. The Centers for Medicare and Medicaid Services (CMS) utilizes many NQF endorsed and HEDIS metrics in their programs, and these metrics are at the foundation of all the CMS programs represented in the list.

The metric alignment list provides information on measures that track to improving care transitions. The list contains 95 essential measures, and is aligned to each TOC Standard. This list provides a much smaller subset of the over 2500 care transition related quality metrics available across multiple quality programs and practice settings. However, it is our intent to synthesize these measures and highlight those most appropriate to improving performance on each standard.

The nine consensus measures are shown in the table below and are also displayed in the gold box at the bottom of each Metric Alignment list. The consensus measures are intended to guide evaluation efforts of the standards and have been endorsed by the Executive Steering Committee. Process measures are intended to evaluate performance in implementing the standards, and outcome measures are intended to assess the impact on quality, utilization, patient satisfaction and cost of care.

As quality measures continue to evolve in this dynamic healthcare environment, ACMA is committed to periodically review and update this list to ensure the identified metrics remain meaningful and may amend or add measures over time.

<b>Consensus Measures</b>	
<b>Process Measures (HEDIS) – measures performance</b>	<b>Outcome Measures (Varied Programs) – measures impact</b>
Evidence of inpatient admission documentation to primary care provider	Evidence of completion of a health risk assessment (CMS: IQR/OQR 2624)
Evidence of receipt of discharge information on the day of discharge or the following day	Evidence of high risk medication assessment in elderly (CMS IQR/OQR 0022)
Evidence of patient engagement (office, home, telehealth visits) provided within 30 days after discharge	Evidence of advance care planning documentation (CMS 0326)
Evidence of medication reconciliation on date of discharge	Evidence of bilateral exchange of necessary patient information (CMS IA_CC_13)
	Evidence of longitudinal care management for patients at high risk for adverse health outcomes or risk (CMS IA_PM_14)

## Transition of Care Standards | METRIC ALIGNMENT LIST

*These essential care transition measures are identified by source reference, should be impacted by effective care transition and may be metrics organizations are already collecting.*

	CMS MEASURES*				CAHPS MEASURES	HEDIS MEASURES
	IQR and OQR	MSSP	MIPS	Medicare Part C and D Star Metrics		
<b>Standard 1.0</b>  <b>Identify Patients at Risk for Poor Transitions</b>	<b>2624</b> Functional outcome assessment – Patient completed questionnaires designed to measure a patient's physical limitations in performing the usual human tasks of living and to directly quantify functional and behavioral symptoms	<b>ACO-8</b> All condition readmission	<b>IA_PM_11</b> Implementation of regular reviews of targeted patient population needs	<b>C08</b> Special needs plan (SNP) care management (Domain: health plan reporting)	<b>CAPHS/ ACO-7</b> Health Status/Functional status	<b>(AAP)</b> Adults' Access to Preventive/ Ambulatory Health Services
	<b>0418</b> Screening for depression- Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	<b>ACO-18</b> Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	<b>IA_PM_13</b> Proactively manage chronic and preventive care for empaneled patients	<b>C09</b> Care for older adults- medication review (Domain: managing chronic long-term conditions)		<b>(PCR)</b> Plan All-Cause Readmissions
		<b>ACO-27</b> Diabetes: Hemoglobin A1c Poor Control		<b>C10</b> Care for older adults- functional status assessment (Domain: safety, managing chronic long-term conditions)	<b>C23</b> Getting appointments and care quickly (member experience with health plan)	<b>(HPC)</b> Hospitalization for Potentially Preventable Complications
		<b>ACO-30</b> Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic		<b>C18</b> Reducing the risk of falling (Domain: staying healthy)	<b>C27</b> Care coordination (member experience with health plan)	<b>(TRC)</b> Notification of inpatient admission

<b>Standard 1.0</b>  <b>Identify Patients at Risk for Poor Transitions</b>	<b>ACO-35</b> Skilled Nursing Facility 30-Day All-Cause Readmission Measure		<b>C21</b> Plan all-cause readmission (Domain: managing chronic long-term conditions)		
	<b>ACO-36</b> All-Cause Unplanned Admissions for Patients with Diabetes				
	<b>ACO-37</b> All-Cause Unplanned Admissions for Patients with Heart Failure				
	<b>ACO-38</b> All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions				
	<b>ACO-40</b> Depression Remission at 12 Months				

**Consensus Measures:**  
**Process: Notification of inpatient admission (HEDIS)**

**Outcome: Evidence of completion of a health risk assessment (CMS: IQR/OQR 262)**



	CMS MEASURES*				CAHPS MEASURES	HEDIS MEASURES
	IQR and OQR	MSSP	MIPS	Medicare Part C and D Star Metrics		
<b>Standard 2.0</b>  <b>Complete a Comprehensive Transition Assessment</b>	<b>2605</b> Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or other Drug Dependence			<b>C20</b> Medication reconciliation post discharge (Domain: patient safety, managing chronic long-term conditions)	<b>C23</b> Getting appointments and care quickly (Domain: member experience with health plan)	<b>(TRC)</b> Receipt of discharge information
	<b>0228</b> Care transition assessment/ 3 Item Care Transition Measure (CTM3)- Uni-dimensional self-reported survey that measures the quality of preparation for care transitions					
	<b>3235</b> Hospice and Palliative Care Composite Process Measure: Comprehensive Assessment at Admission				<b>C27</b> Care coordination (Domain: member satisfaction with health plan)	

**Standard 2.0**

**Complete a Comprehensive Transition Assessment**

**0326**  
Advance Care Planning- Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

**D09**  
Getting needed prescription drugs (Domain: member experience with health plan)

**Consensus Measures:**

**Process: Receipt of discharge information immediately following discharge (HEDIS)**

**Outcome: Evidence of advance care planning documentation (CMS IQR/OQR 0326)**

	CMS MEASURES*				CAHPS MEASURES	HEDIS MEASURES
	IQR and OQR	MSSP	MIPS	Medicare Part C and D Star Metrics		
<b>Standard 3.0</b>  <b>Perform and Communicate a Medication Reconciliation</b>	<b>0097</b> Medication reconciliation post discharge	<b>ACO-12</b> Medication Reconciliation Post Discharge	<b>IA_PM_16</b> Manage medications to maximize efficiency, effectiveness and safety	<b>C 20</b> Medication reconciliation post-discharge	<b>HCAHPS/ Acute Care</b> Q 16- communication about medicines Q 17- communication about medicines	<b>(MPM)</b> Annual Monitoring for Patients on Persistent Medications
	<b>0022</b> High risk medication assessment in elderly			<b>D11</b> Medication adherence for diabetes		<b>(MRP)</b> Medication Reconciliation Post-Discharge
	<b>0419</b> Documentation of medications in EMR			<b>D12</b> Medication adherence for HTN		<b>(DDE)</b> Potentially Harmful Drug-Disease Interactions in the Elderly
				<b>D13</b> Medication adherence for cholesterol		<b>(DAE)</b> Use of High-Risk Medications in the Elderly
						<b>(UOD)</b> Use of Opioids at High Dosage, multiple providers
						<b>(TRC)</b> Medication reconciliation post-discharge

**Consensus Measures:**

**Process: Evidence of medication reconciliation on date of discharge (HEDIS)**

**Outcome: Evidence of high risk medication assessment in elderly (CMS IQR/OQR 0022)**

	CMS MEASURES*				CAHPS MEASURES	HEDIS MEASURES
	IQR and OQR	MSSP	MIPS	Medicare Part C and D Star Metrics		
<b>Standard 4.0</b>  <b>Establish a dynamic care management plan that addresses all settings throughout the continuum of care</b>	<b>216</b> Admission to hospice in less than 3 days before death		<b>IA_PM_14</b> Provide longitudinal care management to patients at high risk for adverse health outcome or harm		<b>HCAHPS/ Acute Care</b> Q 19- information regarding recovery at home Q 20-how do you rate hospital	<b>(FUH)</b> Follow-Up After Hospitalization for Mental Illness
	<b>0497</b> Median time (in minutes) from admit decision time to time of discharge from the ED		<b>IA_PM_15</b> Provide episodic care management, including management across transitions and referrals		<b>C27</b> Care coordination (Domain: member experience with health plan)	<b>(FUH)</b> Follow-Up After Emergency Department Visit for Mental Illness
	<b>0326</b> Advance Care Planning- Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan		<b>IA_CC_10</b> Implementation of practices/processes to develop regularly updated individual care plans			<b>(FUA)</b> Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
			<b>IA_CC_10</b> Implementation of practices/processes for care transition			<b>(FMC)</b> Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions
			<b>IA_BE_14</b> Engage patients and families to guide improvement in the system of care			<b>(TRC)</b> Patient engagement after discharge(office, home, telehealth visits

**IA\_BE\_15**  
Engage patients,  
family and  
caregivers in  
developing a plan of  
care and prioritizing  
their goals

**Consensus Measures:**

**Process: Patient engagement after inpatient discharge (HEDIS)**

**Outcome:**

**Evidence of longitudinal care management for patients at high risk for adverse health outcomes or risk (CMS IA\_PM\_14)**

	CMS MEASURES*				CAHPS MEASURES	HEDIS MEASURES
	IQR and OQR	MSSP	MIPS	Medicare Part C and D Star Metrics		
<b>Standard 5.0</b>  <b>Communicate Essential Care Transition Information to Key Stakeholders across the Continuum of Care</b>	<b>1798</b> All cause hospital wide unplanned readmission		<b>IA_CC_1</b> Performance of regular practices to implement specialist reports to close referral loop		<b>HCAHPS/ Acute Care</b>  Q1- nurse communication  Q2- physician communication  Q3 timeliness of help  Q5-medication explanation	<b>(TRC) Transitions of Care</b>  Notification of inpatient admission  Receipt of discharge instructions  Patient engagement post discharge  Medication reconciliation post discharge
	<b>0517</b> Communication between providers and patients		<b>IA_CC_2</b> Timely communication of test results	<b>C34</b> Call Center – foreign language interpreter and TYY (call center)	<b>HCAHPS/ Home Health Q2</b> Q15-informed of appointments Q17-easy to understand instructions Q18-agency listens carefully Q22- received needed help/support Q23-timeliness of advice/support	
	<b>2380</b> Re-hospitalization first 30 days of home health		<b>IA_CC_8</b> Implementation of practices/processes that document care coordination activities	<b>D01</b> Call Center – foreign language interpreter and TYY (Domain: call center)	<b>CAHPS/ Health Plan</b> Q12-Doctor explained things in a way that was easy to understand Q13-Doctor listened carefully to enrollee	

<b>Standard 5.0</b>  <b>Communicate Essential Care Transition Information to Key Stakeholders across the Continuum of Care</b>	<b>2502</b> All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)		<b>IA_CC_9</b> Implementation of practices/processes to develop regularly updated individual care plans	<b>D06</b> Beneficiary access and performance problems (Domain: health plan compliance)	<b>CAHPS/Hospice</b> Team communication category-While your family member was in hospice care, how often did the hospice team keep you informed about your family member's condition?	
	<b>2512</b> All cause, unplanned readmission first 30 days, Long Term Care facility		<b>IA_CC_10</b> Implementation of practices/processes for care transition that include documentation		<b>CAHPS/ACO-1</b> Getting Timely care, Appointments, and Information	
	<b>0291</b> ED use for patients receiving home health within 30 days		<b>IA_CC_11</b> Establish standard operations to manage transitions of care		<b>CAHPS/ACO-2</b> How Well Your Providers Communicate	
	<b>0173</b> ED use of patients using home health in 60 days		<b>IA_CC_12</b> Establish effective care coordination and active referral management		<b>CAHPS/ACO-6</b> Shared Decision Making between patient, family, physician	
			<b>IA_CC_13</b> Ensure that there is bilateral exchange of necessary patient information		<b>C27</b> Care coordination (Domain: member experience with health plan)	
			<b>IA_CC_14</b> Develop pathways to neighborhood/ community-based resources			
			<b>IA_BE_20</b> Provide condition - specific chronic disease self-management support programs			

**Consensus Measures:**

**Process: Receipt of discharge information after inpatient admission (HEDIS)**

**Outcome: Evidence of bilateral exchange of necessary patient information (CMS IA\_CC\_13)**

# APPENDIX B

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## Organizational Self-Assessment Towards Achievement of Standards: Performance Based Evaluation of Expected Services Delivery



Organizational Self-Assessment

# STANDARD 1.0 Identify Patients at Risk for Poor Transitions

Processes are in place to identify individuals at risk for poor transitions so that appropriate measures can be taken by care team members at any location on the continuum to ensure optimum patient health outcomes.

Health care entities can meet this standard through evidence of the following essential health risk identification elements:

	Consistently Performing (3)	Frequently Performing (2)	Inconsistently Performing (1)	Not Performing (0)	SCORE
Use of a validated risk assessment tool that meets regulatory requirements for the care delivery setting and assigns a quantifiable risk score that can be measured.					
Communication of health risk assessment findings to known episodic or longitudinal care managers across the care continuum.					
Reassessment at each episode of care or transition to a new care setting for those identified as at-risk.					
Implementation of performance improvement processes to identify root causes for failed transition or readmission.					
Screen for medical, behavioral and social factors associated with high-risk for poor transitions, including social determinants of health. <ul style="list-style-type: none"> <li>• Frequent facility admissions and/or inappropriate utilization of health care resources</li> <li>• Polypharmacy and/or poor medication adherence</li> <li>• Multiple co-morbidities and/or 2+ chronic conditions</li> <li>• Cognitive or functional impairments</li> <li>• Behavioral Health Issues</li> <li>• Social determinants</li> </ul>					
Incorporate proactive, predictive-risk modeling of specific patient populations through the analysis of internal and external information, such as state, community, institutional or payer data sets.					

	Consistently Performing (3)	Frequently Performing (2)	Inconsistently Performing (1)	Not Performing (0)	SCORE
Optimization of available technologies to deliver the services associated with the standard					
<b>Standard 1.0 Organization Score:</b>					
<i>Consensus Measures</i>					
<b>Process:</b> Notification of inpatient admission (HEDIS)					
<b>Outcome:</b> Evidence of completion of a health risk assessment (CMS: IQR/OQR 262)					

## SCORING

**Consistently** is defined as performance of service/task **80% or greater**

**Frequently** is defined as performance of service/task **50% - 79%**

**Inconsistently** is defined as performance of service/task **20% - 49%**

**Not performing** is defined as performance of service/task **less than 20%**

# STANDARD 2.0 Complete a Comprehensive Transition Assessment

Processes are in place to conduct a comprehensive transition assessment for patients identified as high-risk for poor transitions across care settings. Attention is given to further identify patients who may become at risk in the new setting.

Show evidence that the comprehensive transition assessment is completed and that the following elements are included:

	Consistently Performing (3)	Frequently Performing (2)	Inconsistently Performing (1)	Not Performing (0)	SCORE
Review of relevant healthcare utilization across all settings including recent provider orders, payer benefits, preferred networks, provider orders when available.					
Solicit patient, family and caregiver goals for care and potential transitions for settings and levels of care.					
Evaluate and document patient/family/caregiver engagement and understanding of current health status.					
Assess self-management abilities, which may include activities of daily living (ADL), instrumental activities of daily living (IADL), patient’s decision-making ability and/or willingness to participate in care planning discussions.					
Review of social determinants of health status, noting risk factors.					
Complete a medication reconciliation and medication and assess medication adherence.					
Review and document patient care goals according to the regulations that govern the care setting and, when appropriate, identify the patient’s designated decision maker.					
Examination of advance care planning documents ensuring they are current and complete.					
Communication of assessment summary and plan of care to provider and next care setting					
<b>Standard 2.0 Organization Score:</b>					
<b>Consensus Measures</b>					
<b>Process:</b> Receipt of discharge information immediately following discharge (HEDIS)					
<b>Outcome:</b> Evidence of advance care planning documentation (CMS IQR/OQR 0326)					

## SCORING

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**Frequently** is defined as performance of service/task **50% - 79%**

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**Not performing** is defined as performance of service/task **less than 20%**

# STANDARD 3.0 Perform and Communicate a Medication Reconciliation

Processes are in place to support a reconciled medication list at each care transition point.

	Consistently Performing (3)	Frequently Performing (2)	Inconsistently Performing (1)	Not Performing (0)	SCORE
Compile a full medication history, including both prescribed and non-prescribed medications, from all available sources.					
Identify patients who may be at high-risk for medication related adverse events or non-adherence due to polypharmacy, opioids, high-cost / specialty drugs. Consult pharmacist.					
Review medication history against active medications in the current setting.					
Verify medication adherence with patient/caregiver					
Assess and document adherence and access barriers, including coverage, affordability, and transportation, and collaborate with prescribing providers.					
Document all medication reconciliation activities in medical record, using applicable coding.					
<b>Standard 3.0 Organization Score:</b>					
<b>Consensus Measures</b>					
<b>Process:</b> Evidence of medication reconciliation on date of discharge (HEDIS)					
<b>Outcome:</b> Evidence of high risk medication assessment in elderly (CMS IQR/OQR 0022)					

## SCORING

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# STANDARD 4.0

## Establish a dynamic care management plan that addresses all settings throughout the continuum of care

Processes are in place to support the development of an ongoing care management plan, created with input from the patient, provider, primary caregiver, and family. This care plan should be accessible to all care managers and remain with the patient’s regular ambulatory care provider for continuity.

	Consistently Performing (3)	Frequently Performing (2)	Inconsistently Performing (1)	Not Performing (0)	SCORE
Review of all available data, including information gathered from patient self-report or from individuals within the patient’s support network.					
Review goals for care and potential transitions for settings and levels of care with patient/family/caregiver.					
Tracking methodology for high-risk patients with an ongoing care management plan.					
Identify and document: <ul style="list-style-type: none"> <li>• Regular ambulatory care provider</li> <li>• Health plan benefits and any requirements or authorizations for services</li> <li>• Designated caregivers</li> <li>• Pharmacy/pharmacies used</li> <li>• Specialty care providers</li> <li>• Home health/home care provider</li> <li>• Social service agencies</li> <li>• Known episodic or longitudinal care manager</li> </ul>					
Identification and documentation of advance care planning documents.					
Consult pharmacy as appropriate, with documentation of the outcome and evidence of patient/family/caregiver awareness and understanding of the necessary course of action.					
Evidence of timely reassessments as the patient moves across care settings.					
Documentation of referrals and linkages to community resources and services.					
Documentation of patient and support network to referrals and linkages.					
Supporting documentation that services and referrals meet payer expectations and requirements.					
Utilization of available technologies to maximize accuracy with the ability to efficiently transfer care plan information across the care continuum (patient, caregiver, provider, and longitudinal/episodic care					

managers), using secure data exchanges and paperless systems when possible					
Identification of episodic or longitudinal care managers coordinating transitions across the care continuum.					
Communication and sharing of the care plan to known episodic or longitudinal care managers across the continuum.					
<b>Standard 4.0 Organization Score:</b>					
<i>Consensus Measures</i>					
<b>Process:</b> Patient engagement after inpatient discharge (HEDIS)					
<b>Outcome:</b> Evidence of longitudinal care management for patients at high risk for adverse health outcomes or risk (CMS IA_PM_14)					

## SCORING

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**Not performing** is defined as performance of service/task **less than 20%**

# STANDARD 5.0

## Communicate Essential Care Transition Information to Key Stakeholders Across the Continuum of Care

Processes are in place to ensure the timely transfer of essential TOC information to key stakeholders including the caregiver, the regular ambulatory care provider, the payer and the identified episodic care manager in the next care setting.

	Consistently Performing (3)	Frequently Performing (2)	Inconsistently Performing (1)	Not Performing (0)	SCORE
Identify appropriate TOC stakeholders including patient, caregivers, provider, specialists, payers, health systems.					
A standardized, securely maintained framework for TOC communication transfer is used.					
Deploy communications electronically whenever possible, using secure or encrypted technologies.					
Information transfer includes acknowledgement of receipt.					
Communicate essential transition information at time of TOC, including clinical and social determinants of health, and current barriers to goals.					
<b>Standard 5.0 Organization Score:</b>					
<b>Consensus Measures</b>					
<b>Process:</b> Receipt of discharge information after inpatient admission (HEDIS)					
<b>Outcome:</b> Evidence of bilateral exchange of necessary patient information (CMS IA_CC_13)					

### SCORING

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