AMERICAN CASE MANAGEMENT ASSOCIATION

TRANSITIONS OF CARE STANDARDS

A new way forward

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INTRODUCTION

The healthcare environment is evolving toward a patient-centered, value-based model that requires healthcare organizations to be accountable for both the cost and quality of care. This model, articulated by the Institute for Healthcare Improvement's (IHI) Quadruple Aim, promotes coordination across settings, collaboration between providers to assure care that is safe, efficient, and cost-effective. The term *care transition* describes a process of transferring a patient from one care setting or level of care to another, such as from hospital to home, hospital to skilled nursing facility or taking steps in the home to avoid the need for care in another setting. These transitions are particularly vulnerable points in the healthcare continuum.

Transitional care refers to the actions taken by physicians and other healthcare providers to ensure coordination, resource management, and continuity of care during these transfers. It is critical that crucial information is collected and communicated effectively, ensuring that patients receive seamless, comprehensive care in every treatment setting. It is well understood that poorly managed transitions impact quality and costs. According to the Centers for Medicare and Medicaid Services (CMS), the costs related to poorly managed care transitions of Medicare patients from acute care alone is $26 billion per year (2016 data) of 2016.[1] To address this, CMS has instituted projects such as the Hospital Readmissions Reduction Program (HRRP) and the Medicare Shared Saving Program (MSSP), which incentivize investments to improve care transitions as a means to achieve positive outcomes and reduce costs.

ACCORDING TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS), THE COST OF POOR CARE TRANSITIONS OF MEDICARE PATIENTS FROM ACUTE CARE ALONE IS **$26 BILLION PER YEAR AS OF 2016.**[1]

Healthcare mergers and acquisitions continue to occur, with larger health systems expanding their footprint across multiple different settings and markets. This can be confusing for patients, families and system employees. From a patient safety perspective, it is crucial for care management clinicians to have a clear understanding of their care delivery system as they navigate patients across a growing continuum of care. As health systems assume risk under value-based care models, the resources needed to support effective, longitudinal care coordination have become increasingly important. The ACMA TOC Standards provide a roadmap to guide the implementation of care coordination models necessary for value-based care.

The American Case Management Association (ACMA) is well known for its ability to convene Case Management and Transitions of Care professionals who are directly responsible for care coordination. ACMA established Standards for Case Management practice, and now broadens its scope to include the development of Transition of Care (TOC) Standards. ACMA views care transitions as dynamic processes to create, communicate, implement and adjust a patient's care plan to meet their individualized needs. These TOC standards assist providers, payers and all healthcare organizations in establishing processes for seamless coordination across the entire continuum of care, with the goal of achieving the best health outcomes. Pfizer recognizes that effective care transitions are critical to patients' medication adherence and health outcomes and has provided funding to support the development and implementation of the ACMA Transition of Care Standards.

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[1] Final Evaluation Report: Evaluation of the Community-based Care Transitions Program, November 2017, Econometrica, Inc. https://downloads.cms.gov/files/cmmi/cctp-final-eval-rpt.pdf

THE CHALLENGE

Coordination of Care for Complex, At-Risk Patients Across the Care Continuum

Silos in care delivery exist across the healthcare continuum. Technology limitations, misalignment of resources, the shift towards primary care physicians no longer following their hospitalized patients and restricted communication across care settings prevent optimal information handoff as patients move between care settings. There is variability in the skills, capabilities and preparation of the people managing care transitions across the continuum. Regulators, physicians, payers and community agencies may all use the term "transitions of care," but often assume different definitions and have varied expectations. Additionally, the evaluation of performance outcomes is made difficult by the lack of consistent or uniform metrics across care settings. The ACMA TOC Standards serve to reduce the number of silos, increase the availability and provision of information during care transitions and provide a framework to implement and evaluate a process to improve care transitions that is applicable in all settings.

While patient acuity continues to rise in hospitals across the nation, there is an accompanying focus on reducing hospital length of stay and avoiding related readmissions. This requires hospitals to focus on care transition planning immediately upon hospital admission. Medically complex patients often have equally challenging social and environmental issues that impact their health. Addressing these issues during the vulnerable transition period is key, and requires expertise to assess, plan and coordinate the transition to the next setting.

Value-based payment (VBP) programs that are moving away from fee for service models promote the delivery of the right care in the right setting, providing financial incentives for achieving quality standards and eliminating unproductive costs from the system. The VBP model aligns incentives to encourage collaboration among disparate providers to achieve objectives. Cost savings can be shared with nursing homes, behavioral health providers, specialists, hospitals, home and community-based providers, and others who are creating value for both the beneficiary and the system. High-cost, complex patients often have suboptimal outcomes because of inadequate coordination. Improved handoffs as patient's transition from one provider to the next and better coordination are key strategies in VBP programs. Additionally, VBP structures utilize assessment measures like *all cause readmissions* and *post-acute follow-up* which are broadly applicable across all these providers. A well-structured VBP model draws attention to the full continuum of healthcare services including long-term services and supports (LTSS) and behavioral health services, which have traditionally been of little interest to providers not directly involved in providing these services. We believe the ACMA Transitions of Care standards will serve as a framework to support and guide organizations and care managers to achieve these care coordination goals.

Healthcare professionals who practice in one particular care setting may be unfamiliar with the requirements and nuances of care delivery in other settings. This can contribute to fragmentation and poorly planned care transitions. A commitment to improve care transitions requires adjusting from an episodic viewpoint to a longitudinal view as patients' journey through all care settings necessary to address their health needs. This commitment also demands better communication, recognition of differences in staffing and resources and the identification of information necessary to deliver optimal care in each setting. It is increasingly important to find ways to manage patients with multiple, complex needs, who are receiving a variety of treatments and medications, require longitudinal care coordination across various settings and have multiple episodes of care.

"TRANSITION EFFORTS TARGETING VULNERABLE POPULATIONS CAN MAXIMIZE THE USE OF APPROPRIATE, HIGH QUALITY SERVICES, REDUCE CONFUSION AND COST, AND ENHANCE A PATIENT'S EXPERIENCE OF CARE..."

- Charlotte Crist, Managing Director, Clinical Programs, Blue Cross / Blue Shield of Rhode Island

EXPERIENCE AND EXPERTISE

Designing the TOC Standards

The Executive Steering Committee has guided the development of the care transition standards and associated services. A committee of healthcare executives representing care settings and key stakeholders across the full spectrum of patient care designed the standards so that they are realistic in the current healthcare environment, forward-thinking and aspirational. It is the goal that these standards can be implemented across all care settings to keep pace with rapidly evolving care delivery.

Members of the Executive Steering Committee are listed on page 44 and included the following:

- **Case Management Leaders**
- **Chief Clinical (Medical and Nursing) Officers**
- **Chief Financial Officers**
- **Medical Directors, Case Management Physician Advisors**
- **National Associations for Home Care, Hospice, Pharmacy and Long-Term Care**
- **Payers actively supporting transitional care models**

GUIDING PRINCIPLES

The principles that guided the Executive Committee in the design of the Transition of Care standards are listed here.

Guiding Principles for the Development of Transition of Care Standards

The desired outcome for the development of Transition of Care standards is to:

1. Deliver a framework of minimum elements necessary to support seamless transitions of care between settings across the continuum
2. Provide coordinated, efficient, cost effective, collaborative care transitions, aligned with existing and evolving safety and quality measures
3. Standardize practices to guide transitions between levels and settings of care
4. Align with regulations and incentives across care delivery settings and payers
5. Ensure patient and family engagement in planning and execution of all transitions
6. Promote the concept of a longitudinal care manager (provider, payer, or others) for those at high risk for poor transitions
7. Identify and partner with community, including faith-based and social organizations.
8. Expand access to relevant information and maximize the use of available technology

THE NEED FOR A SHIFT FROM EPISODIC TO LONGITUDINAL CARE MANAGEMENT

Today, transitions between care settings or levels of care are most often episodic in nature and the case manager is focused on the immediate transfer of information to a discrete point on the care continuum. In today's environment, care management is most often resourced to reflect this construct of care coordination. These standards assure leading practice for today's dynamic environment while aspiring to promote a more comprehensive approach to care coordination.

To move the needle on improving care transitions, the ACMA TOC Standards discuss the concept of a longitudinal care manager (LCM) and encourages the adoption of this role whenever possible. As an introduction, the LCM, working as part of the primary care team, or alongside the primary care provider, can be the *one constant* accountable to ensure bidirectional communication of the care plan across multiple settings. The LCM may be situated in a variety of settings such as a health plan, a primary care office, or as part of an advanced primary care model such as a Patient Centered Medical Home (PCMH) or an Accountable Care Organization (ACO). While LCMs are not currently incorporated into most traditional health settings, *one intent of these standards is to support the adoption of the LCM role,* recognizing the contribution such a role is likely to make towards enhanced coordination. To be successful, the LCM must have an understanding of the care delivered in multiple different settings and have well-developed relationships across the system of care. The LCM can improve the success of transitional care, decrease costs and unnecessary utilization and enhance the care experiences of both patients and providers.

For too long, we have tolerated a fragmented system of care, inadequate communication, and poorly handled transitions of care. This has had costly results. Researchers' estimate that the average U.S. hospital loses $ 1.7 million per year due to poor coordination and communication among members of the staff.[2] Imagine the future if these costs could be saved, and applied to expanding resources to leverage the LCM role to assist at risk populations.

It is also the intent of the TOC Standards to demonstrate the return on investment (ROI)associated with implementing these practices. The organizational self-assessment is designed to help leaders assess the current state of care management practices across a system, identify gaps and implement measurable solutions to enhance their programs. The Standards also provide process and outcome metrics which have been selected from a variety of quality assessment programs. These essential measures can assist organizations to evaluate improvements in transitional care.

[2] Bresnick, Jennifer. "Inefficient communication cost a hospital 1.7 million a year. Health IT Analytics." Retrieved September, 2018 from: http://healthitanalytics.com/2014/07/15/inefficient-communication-costs-a-hospital-1-7-million-a-year/

CONCEPTUAL FRAMEWORK FOR TOC STANDARDS

The TOC standards are intended as a common framework for all healthcare settings, to foster effective, high quality and efficient care transitions. They are designed in such a way that:

1. They may be applied across care settings

2. They help organizations assess, quantify and identify gaps in their current care transition work plan

3. Leaders may use them to identify opportunities to modify current staffing and transition of care processes.

4. They use recommended quality and improvement measures to guide relevant data collection

5. They help organizations prepare for longitudinal care coordination and drive accountability across all care settings, which is aligned with value-based reimbursement models

6. They help establish relationships and broaden connections across all healthcare and community settings

7. They build a foundation to support longitudinal care management strategies

8. They provide a framework to evaluate return on investment (ROI) of care transition efforts as a mechanism to reduce utilization and enhance quality and patient experience (Value Based Care ROI)

Standards

The standards outlined in this document apply across all care settings and reflect the minimum elements necessary to create successful transitions. Each standard describes both the structures and the services required to meet that standard.

Roles

In all settings, those patients and families identified with risk factors for poor or unplanned transitions should be assured management by personnel who have appropriate education, training, certification and professional scope of responsibility for that setting. All roles related to transition services must have a defined scope of practice based on licensure, certification, and training. Many evolving care delivery models leverage non-licensed personnel and community health workers to maximize community-based care. The ACMA TOC Standards seek to assure that qualified individuals, such as clinically competent case managers, perform assessments and direct care transitions.

Every care transition is important. However, care transitions from higher acuity settings such as ICU, acute care, inpatient rehabilitation, inpatient behavioral health, long-term acute care (LTAC), and skilled nursing facilities are often more complicated and have unique priorities. These care settings are generally staffed with nurses, care managers, social workers, and pharmacists who are available to provide the critical communication and documentation needed to ensure a safe transition.

Transitions from ambulatory care settings, such as the emergency department, outpatient behavioral health programs, Federally Qualified Health Clinics (FQHC), outpatient surgical centers and chronic disease clinics, which include patients with complex medical and social needs, make the transmittal of information and communication required at discharge just as pivotal. In these settings, the availability of physicians/other providers, care managers and social workers varies widely and environments with minimal care management support may find greater challenge in the exchange of a full and complete set of patient information.

Post-acute and other settings such as home, independent or assisted living facilities also present challenges to information transfer because the patient, family or caregiver has more accountability for medication adherence and follow-up appointments.

Payers are critical partners in managing care transitions, especially for more complex patients. Paid claims data can help uncover issues like high service utilization and poor medication adherence that are likely to affect transitions. Payers offer robust utilization and coverage information, broad population-based data, and may also be able to provide longitudinal care management resources. Building a strong, collaborative relationship with payers is recommended to support improved care continuity.

Services

Services within each standard are outlined in a manner that lists the core or most fundamental services first and continues by detailing leading practice and forward-thinking services that assure quality and efficiency. The Executive Steering Committee were united in the view that each standard, while acknowledging resource, setting, and organizational maturity challenges, should include a roadmap for excellence in transitioning care.

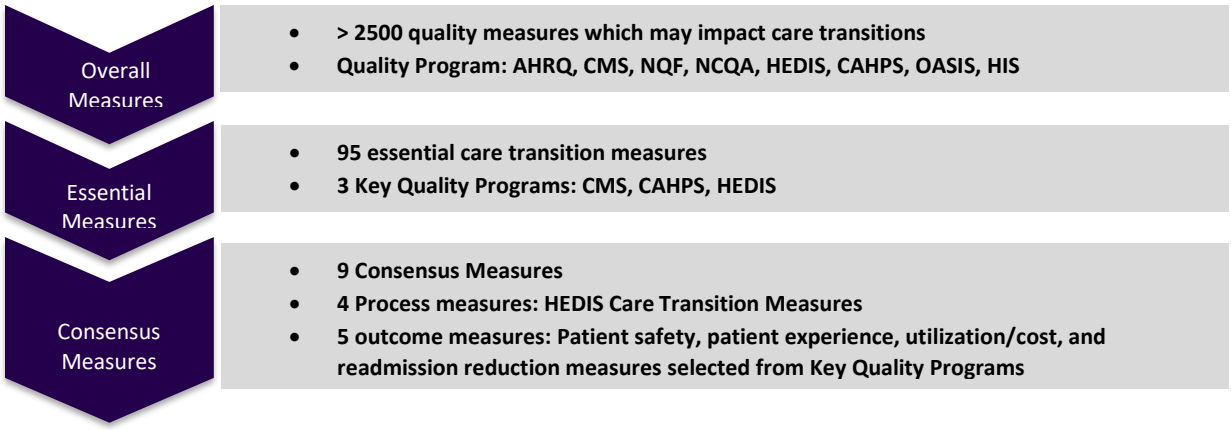
Self-Assessments

Organizational assessments are provided for each standard to aid care management leaders in determining what, if any, services may need to be refined to enhance effective TOC performance. By rating performance on a four-point scale from *Consistently Performing* to *Not Performing,* the self-assessment can help the organization identify opportunities to reallocate resources or modify current processes to support successful care transitions.

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

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."

STANDARDS

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.[2]

[2] 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 – The clinician who is accountable, over the course of time, to oversee care coordination across various care settings for high-risk patients. The clinician may be a primary care provider (PCP), ambulatory care provider, payer or community provider.

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.

APPENDIX A

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.

Consensus Measures	
Process Measures (HEDIS) – measures performance	**Outcome Measures (Varied Programs) – measures impact**
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**		
Standard 1.0 **Identify Patients at Risk for Poor Transitions**	**2624** 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	**ACO-8** All condition readmission	**IA_PM_11** Implementation of regular reviews of targeted patient population needs	**C08** Special needs plan (SNP) care management (Domain: health plan reporting)	**CAPHS/ ACO-7** Health Status/Functional status	**(AAP)** Adults' Access to Preventive/ Ambulatory Health Services
	0418 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	**ACO-18** Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	**IA_PM_13** Proactively manage chronic and preventive care for empaneled patients	**C09** Care for older adults- medication review (Domain: managing chronic long-term conditions)		**(PCR)** Plan All-Cause Readmissions
		ACO-27 Diabetes: Hemoglobin A1c Poor Control		**C10** Care for older adults- functional status assessment (Domain: safety, managing chronic long-term conditions)	**C23** Getting appointments and care quickly (member experience with health plan)	**(HPC)** Hospitalization for Potentially Preventable Complications
		ACO-30 Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic		**C18** Reducing the risk of falling (Domain: staying healthy)	**C27** Care coordination (member experience with health plan)	**(TRC)** Notification of inpatient admission

Standard 1.0 **Identify Patients at Risk for Poor Transitions**		**ACO-35** Skilled Nursing Facility 30-Day All-Cause Readmission Measure		**C21** Plan all-cause readmission (Domain: managing chronic long-term conditions)		
		ACO-36 All-Cause Unplanned Admissions for Patients with Diabetes				
		ACO-37 All-Cause Unplanned Admissions for Patients with Heart Failure				
		ACO-38 All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions				
		ACO-40 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**		
Standard 2.0 **Complete a Comprehensive Transition Assessment**	**2605** Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or other Drug Dependence			**C20** Medication reconciliation post discharge (Domain: patient safety, managing chronic long-term conditions)	**C23** Getting appointments and care quickly (Domain: member experience with health plan)	**(TRC)** Receipt of discharge information
	0228 Care transition assessment/ 3 Item Care Transition Measure (CTM3)- Uni-dimensional self-reported survey that measures the quality of preparation for care transitions					
	3235 Hospice and Palliative Care Composite Process Measure: Comprehensive Assessment at Admission				**C27** 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**		
Standard 3.0 **Perform and Communicate a Medication Reconciliation**	**0097** Medication reconciliation post discharge	**ACO-12** Medication Reconciliation Post Discharge	**IA_PM_16** Manage medications to maximize efficiency, effectiveness and safety	**C 20** Medication reconciliation post-discharge	**HCAHPS/ Acute Care** Q 16- communication about medicines Q 17- communication about medicines	**(MPM)** Annual Monitoring for Patients on Persistent Medications
	0022 High risk medication assessment in elderly			**D11** Medication adherence for diabetes		**(MRP)** Medication Reconciliation Post-Discharge
	0419 Documentation of medications in EMR			**D12** Medication adherence for HTN		**(DDE)** Potentially Harmful Drug-Disease Interactions in the Elderly
				D13 Medication adherence for cholesterol		**(DAE)** Use of High-Risk Medications in the Elderly
						(UOD) Use of Opioids at High Dosage, multiple providers
						(TRC) 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**		
Standard 4.0 **Establish a dynamic care management plan that addresses all settings throughout the continuum of care**	**216** Admission to hospice in less than 3 days before death		**IA_PM_14** Provide longitudinal care management to patients at high risk for adverse health outcome or harm		**HCAHPS/ Acute Care** Q 19-information regarding recovery at home Q 20-how do you rate hospital	**(FUH)** Follow-Up After Hospitalization for Mental Illness
	0497 Median time (in minutes) from admit decision time to time of discharge from the ED		**IA_PM_15** Provide episodic care management, including management across transitions and referrals		**C27** Care coordination (Domain: member experience with health plan)	**(FUH)** Follow-Up After Emergency Department Visit for Mental Illness
	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		**IA_CC_10** Implementation of practices/processes to develop regularly updated individual care plans			**(FUA)** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
			IA_CC_10 Implementation of practices/processes for care transition			**(FMC)** Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions
			IA_BE_14 Engage patients and families to guide improvement in the system of care			**(TRC)** 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**		
Standard 5.0 **Communicate Essential Care Transition Information to Key Stakeholders across the Continuum of Care**	**1798** All cause hospital wide unplanned readmission		**IA_CC_1** Performance of regular practices to implement specialist reports to close referral loop		**HCAHPS/ Acute Care** Q1- nurse communication Q2- physician communication Q3 timeliness of help Q5-medication explanation	**(TRC) Transitions of Care** Notification of inpatient admission Receipt of discharge instructions Patient engagement post discharge Medication reconciliation post discharge
	0517 Communication between providers and patients		**IA_CC_2** Timely communication of test results	**C34** Call Center – foreign language interpreter and TYY (call center)	**HCAPHS/ Home Health** Q2 Q15-informed of appointments Q17-easy to understand instructions Q18-agency listens carefully Q22- received needed help/support Q23-timeliness of advice/support	
	2380 Re-hospitalization first 30 days of home health		**IA_CC_8** Implementation of practices/processes that document care coordination activities	**D01** Call Center – foreign language interpreter and TYY (Domain: call center)	**CAHPS/ Health Plan** Q12-Doctor explained things in a way that was easy to understand Q13-Doctor listened carefully to enrollee	

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

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

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. • 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					
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					
				Standard 1.0 Organization Score:	
Consensus Measures **Process:** Notification of inpatient admission (HEDIS)					
Outcome: 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					
				Standard 2.0 Organization Score:	

Consensus Measures

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

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

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 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.					
				Standard 3.0 Organization Score:	

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)

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 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: • Regular ambulatory care provider • Health plan benefits and any requirements or authorizations for services • 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.					
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.					
Standard 4.0 Organization Score:					

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)

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%**

Organizational Self–Assessment

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.					
Standard 5.0 Organization Score:					

Consensus Measures

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

Outcome: Evidence of bilateral exchange of necessary patient information (CMS IA_CC_13)

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%**

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