## What Will It Take to Improve Quality and Safety During Care Transitions?


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## Foster Greater Engagement of Patients and Family Caregivers

- Meet consumers where they are with respect to health literacy, cognition, and level of activation in order to provide customized care planning.
- Encourage patients to express their preferences and then honor these preferences for type of services they desire, the intensity of health care services they receive, and the settings in which they receive them.



## Elevate the Status of Family Caregivers to Essential Members of the Care Team

- We cannot afford to ignore the very individuals we rely upon to execute the care plan, monitor patient safety, and serve as de facto care coordinators.
- Treat as full-fledged members of interdisciplinary teams with direct input into the development of the care plan.



## Implement Performance Measurement

- Principles of "Lean Thinking" state we must reach out to our "customers" [patients] for their input.
- Thus an important quality improvement strategy incorporates the patient's voice and paves the way for establishing accountability.



## Define Accountability During Transitions

- Patients making transitions need to understand who is the accountable professional overseeing their care at all times.
- The Transitions of Care Consensus Policy Statement states that the sending care team maintains responsibility for the care of the patient until the receiving care team has had the opportunity to:
  - review and respect the goals for care
  - to review the transfer information
  - clarify any outstanding questions
  - acknowledge assumption of responsibility



## Build Professional Competency in Care Coordination

- Most health care professionals had little exposure to strategies that promote effective care coordination.
- Transition-specific core competencies requires an appreciation for the differences in culture and care delivery capacity needed to ensure an ideal match between a patient's care needs and his or her care setting.

## Explore Technological Solutions to Improve Cross Setting Communication

- Establish standard operating procedures for the content, timeliness, and mode of health information exchange
- Meaningful use guidelines represent a significant step forward in this regard and provides incentives.



## Align Financial Incentives to Promote Cross Setting Collaboration

- Transitional care exposes one of the greatest weaknesses of our care delivery system—that it is not in fact a system.
- There are opportunities to create synergy between improving transitional care and patient-centered medical homes, the Partnership for Patients, bundled payments, and accountable care organizations.



## Community-Based Care Transitions Program (Section 3026)

- HHS Secretary funds eligible entities to furnish evidence based care transitions services to high-risk Medicare beneficiaries
- Entities include: hospitals with high readmit rates in partnership with community-based organizations
- Started April 2011; Up to $500M of eligible funding
- http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313




*http://www.caretransitions.org/What_will_it_take.asp*

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