Readmissions are an early target of payment reform because they occur frequently and are very costly, and it appears that many can be prevented with more attention to comprehensive discharge planning and care and support during the post-discharge transition.

Key Points

- Hospital efforts to reduce readmissions have become more visible and important because the financial stakes — disincentives being incorporated into payment reform — are now high enough to be noticeable in the bottom line.
- Variability in rates across hospitals and regions of the country suggests that significant reductions are possible if practices in better performing hospitals are adopted more uniformly.
- Current measures employed in Medicare incentives target acute care hospitals and high-risk patients defined as those with heart failure, pneumonia, or an acute myocardial infarction. Any re-hospitalization to any hospital within 30 days, for any condition, is counted.
- Preventing readmissions is very challenging because so many community and patient factors contribute to the problem, many of them outside of the direct control of the hospital.
- However, research, combined with practices in hospitals with a track record of reducing readmissions, shows that comprehensive discharge planning and post-discharge care and support during the transition period reduces readmissions in high-risk patients.
- The next scope of work will be to achieve a formal connection with organized care management for every patient covered by this type of program.
- As more high-risk patients are covered by these programs, this will decrease the role of the hospital in providing post-discharge care and support, but formally link patients back to organizations accountable for ongoing care.
- Key elements of the resulting model will be organizing and operating transitional care as a process in its own right, laying out each patient’s transition and hand-off in a time-limited transition clinical pathway, and new uses of health IT in patient tracking and transition care planning.

Why the Focus on Readmissions

Hospital readmissions were one of the earliest targets of both quality measurement and performance-based incentives for Medicare and other insurance programs. Undoubtedly one reason is that claims provide data for measurement because the payer receives a claim (with some time lag) every time a patient is hospitalized. As a result, one party with a great interest in performance, the payer, also possesses a source of already structured data to measure performance — a rare situation in healthcare quality measurement.

A readmission is defined as a return hospitalization to an acute care hospital that follows a prior acute care admission within a specified time interval, called the readmission time interval. Although policymakers and researchers sometimes use intervals such as 5, 60 or 90 days, current quality measures employed by CMS all use 30 days as the time interval between hospital stays.

A second reason for the national public policy focus on readmissions is that they occur frequently in some populations and are extremely costly, in an era of great concern over the escalating costs of healthcare and a general lack of near-term achievable cost reductions. Most data about the extent of the problem in the
United States is from the nation’s largest health insurance program: Medicare. According to one analysis of Medicare IPPS (fee-for-service) claims, 19.6% of patients discharged from an acute care hospital were re-hospitalized within 30 days and 34% within 90 days. MedPAC calculated that readmissions alone accounted for $15 billion in Medicare spending in 2005.

Another reason that readmissions are an attractive target is the variability in rates observed between individual hospitals and among regions of the country, which offers hope that many hospitals can execute the transition from hospital care more effectively. That there is room for improvement in any hospital has been demonstrated over and over again in reports from individual hospitals in which systematic efforts targeted at high-risk patients have yielded significant and sustained reductions. Clearly not every readmission can be prevented, but estimates are high. MedPAC has estimated that as many as 84% of 5-day Medicare readmissions, 78% of 15-day readmissions and 76% of 30-day readmissions are potentially preventable.

Judging improvement and estimating the potential savings that could be achieved nationwide if better practices were employed more uniformly requires understanding what percentage of readmissions is preventable. Despite several attempts to distinguish preventable from non-preventable readmissions, there is no consensus today about how many readmissions could be avoided if hospitals uniformly adopted better practices. Clearly not every readmission can be prevented, but estimates are high. MedPAC has estimated that as many as 84% of 5-day Medicare readmissions, 78% of 15-day readmissions and 76% of 30-day readmissions are potentially preventable. A more recent meta-analysis of studies estimating preventability found that the median proportion of readmissions deemed avoidable was 27.1% and varied from 5% to 79%, though criteria were often subjective and varied extensively.

Whatever the actual upper limit, even a small decrease could achieve significant savings — not just in healthcare costs, but also in disruption and potentially dangerous deterioration in health status for the patients involved. From the perspective of the patient, any readmission is an adverse event.

### Current Readmissions Measures

Readmission measures and performance-based incentives under Medicare are all targeted at acute care hospitals. As shown below, actual measures are a mix of condition-specific and all-condition readmissions rates.

- **Acute Myocardial Infarction (AMI) 30-Day Risk Standardized Readmission Rate**
- **Heart Failure 30-Day Risk Standardized Readmission Rate**
- **Pneumonia 30-Day Risk Standardized Readmission Rate**
- **30-Day Risk-Standardized, All Condition Readmission**

All CMS measures count any admission to any hospital for any condition (with a few exceptions for intended procedures) within 30 days of discharge from the index hospital stay. Current condition-specific measures target patients admitted for treatment of heart failure, pneumonia or heart attack for the index hospitalization. CMS has already made clear its intent to expand the set of conditions to include patients with chronic obstructive pulmonary disease (COPD) and those undergoing coronary artery bypass graft (CABG) surgery. At a minimum, other likely additions are additional surgical admissions identified by MedPAC as making up almost 30% of spending on readmissions: percutaneous transluminal coronary angioplasty and other vascular procedures.
A number of concerns have been raised about singling out readmissions as the focus of so much public policy and hospital effort. These range from questioning the potential gains available from current approaches because so many community and patient factors outside the control of the hospital contribute to readmissions, to criticism of the measures employed on a number of fronts, including failure to clinically link the index and subsequent admissions (rather than “all-cause” readmissions in current measures) and the use of 30 days as the standard time frame for counting readmissions (as opposed to shorter time frames). So far, despite many rounds of industry and public comment on proposed rules, neither the specific measures nor the incentives to ramp down on readmissions in the Medicare program have changed very much.

**What’s at Stake for Hospitals?**

In addition to public reporting about Medicare readmission rates as part of the measure set for HospitalCompare, the financial stakes for hospitals are high and growing, especially for hospitals that treat a large number of patients with Medicare insurance. Unlike previous CMS restrictions on reimbursement for specific patients that experience readmissions, the Readmission Reduction Program will penalize the lowest performing hospitals (defined in terms of an RSRR or risk-standardized readmission rate) by applying an “adjustment factor” to the base-operating DRG payment that would otherwise apply. This adjustment affects the reimbursement rates for all Medicare patients across the board. For those hospitals participating in one or more Accountable Care Organization (ACO, created under the CMS Shared Savings Program), readmissions not only cut into any potential savings, but are also part of the measure set employed in calculating what portion of the savings is shared with the ACO.

**What’s at Stake in the Medicare IPPS Program**

<table>
<thead>
<tr>
<th>Program</th>
<th>FY 2013</th>
<th>FY2014</th>
<th>FY2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Compare:</strong> Public reporting of Medicare risk-standardized readmission rates for heart failure, pneumonia, heart attack</td>
<td>Likely addition of conditions (COPD, CABG, stroke, hip and knee replacement, vascular procedures)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>QIO review of readmissions</strong> within 31 days to assess standards of care and potentially recommend denial of payment</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Non-payment for same-diagnosis readmission within 24 hours</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Readmission Reduction Program:</strong> Hospitals performing in the lowest quartile for excess readmission ratio</td>
<td>-1% AMI, HF, CHF</td>
<td>-2% +CABG, COPD</td>
<td>-3% +more conditions</td>
</tr>
<tr>
<td><strong>ACO Program:</strong> All-condition readmission rate among the performance measures included in calculation of what portion of savings are shared with the ACO</td>
<td>50-60% of shared savings</td>
<td>50-60% shared savings</td>
<td></td>
</tr>
</tbody>
</table>

Other insurers besides Medicare are targeting readmissions not just for measurement but also in incentive programs. As a result many hospitals either have, or will soon have, multiple programs from Medicaid and private payers that link reimbursement with readmissions performance in some way. As a result, preventing readmissions is becoming a high-profile effort in hospitals, with progress closely followed by executive management and even the trustees.

**What Research Tells Us**

**What patients are at high risk of readmission?**

Combining what can be gleaned from claims with retrospective record reviews of patients with readmissions has provided a list of patient characteristics that are often associated with re-hospitalization. Though most of the reported data are for the Medicare population, care teams in hospitals use this
understanding to identify especially high-risk patients who may benefit from more intensive discharge planning and follow-up. Socio-demographic and healthcare history characteristics likely also add risk of readmission to hospital patients more broadly.\textsuperscript{22}

Medicare Patient Characteristics Associated with Risk of Readmission

| Socio-demographic | • Gender (male)  
|                   | • Poverty (Medicaid or uninsured)  
|                   | • Age (Medicare)  
|                   | • Lack of stable living situation and/or support at home  
|                   | • Low English and/or health literacy  
| Healthcare history | • Index admission for HF, AMI, PN or certain types of surgery  
|                   | • Recent admission(s)  
|                   | • Frequent ED visits  
| Disease burden | • Takes six or more medications  
|                | • CHF, diabetes, COPD  
|                | • Depression, psychoses  
|                | • Cancer, renal or lung disease  
|                | • Alcohol or drug dependency  
| Physical status | • Disabled  
|                | • Frail  
|                | • Signs of poor nutrition  
| Other | • Discharged during a weekend or holiday  

The ability to combine characteristics into more precise risk prediction for specific patients (beyond merely the number of risk factors) would be of great interest clinically, as well as extremely useful in risk-adjusting readmission rates for comparing hospitals or rating performance. According to the most recent evaluation of available models (including those employing primary data in real time), none deals with the full range of potential patient factors (overall health and function, illness severity), most had poor predictive ability, and none supported triaging patients with respect to specific interventions to reduce risk.\textsuperscript{23} This leaves clinical teams in hospitals able to predict which patients may have a difficult transition post-discharge but not much insight into how best to address risks and where to focus efforts.

**Care-related contributors to readmissions**

In addition to patient characteristics that appear to put patients at risk, retrospective review of medical records has shown an association between readmissions and breakdowns in care during the hospitalization and immediate post-discharge period. These are more likely to be influenced by process improvement than, for instance, unpreventable progression of disease.

Common Process Breakdowns Associated with Potentially Preventable Readmissions

| Care Gaps During Stay | • Patient safety (especially medication- and infection-related)  
|                      | • Medication reconciliation not completed or inaccurate at admission or discharge  
| Patient Factors | • Lack of understanding of post-discharge plan of care  
|                 | • Lack of understanding of what to watch for (warning signs), how to respond  
|                 | • Non-compliance with any or all elements of post-discharge self-management and care  
| Lack of Timely Post-Discharge Care | • No appointments available or no relationship with PCP  
|                               | • Logistics, such as no transportation  
|                               | • Primary care physician unaware of hospitalization  
| Communication | • Delayed, lacking or inadequate communication with next provider of direct care  
|               | • Lacking or inadequate communication with home care provider (including family)  

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Both medical errors (especially medication-related) and surgical complications, such as infections, are associated with readmissions. Patients with one patient safety incident during the initial hospitalization had double the risk of readmission (28% versus 14%), according to one study.\textsuperscript{24} A recent broad-based study (patients of all ages) in Canada found that 9.3% of all patients readmitted were returned for complications of surgery, with infection after surgery the most common diagnosis.\textsuperscript{25}

Medication reconciliation is important in preventing post-discharge medication-related events that can lead to readmission. One study found that elderly patients with discrepancies at discharge were more than twice as likely to experience a readmission.\textsuperscript{26}

Patients discharged to the community are substantially on their own for many aspects of their recovery. If they (or assisting family members) fail to understand ongoing treatment and warning signs or do not comply with recommended treatment and follow-up for a variety of reasons, readmissions are more likely. Lack of timely post-discharge care turns out to be an important risk factor. One analysis of Medicare claims showed that one-half of patients with a medical condition readmitted within 30 days did not have a physician visit within that period (no claim submitted).\textsuperscript{27} A subsequent study confirmed that hospitals with heart failure patients experiencing earlier physician follow-up (generally within one week of discharge) had lower rates of readmission for these patients.\textsuperscript{28}

**What Works to Reduce Readmissions**

*General lessons from research*

A great deal of research has been done on readmissions, in the United States and Canada, as well as in Europe and Australia. Heterogeneous target patient populations (though often patients with CHF) and combinations of interventions have been studied, usually with observational rather than experimental design. This makes it difficult to justify applying the results for any model very broadly. Though this is frustrating for those seeking a clearly “evidence-based” approach, there are lessons to guide ongoing work.

- There is no magic bullet. According to one recent systematic review of published research, “no discrete intervention or bundle of interventions appears to reliably reduce re-hospitalization.”\textsuperscript{29}

- However, there are promising approaches with some research validation that also have been employed in many hospitals with a track record of reducing readmissions: patient-centered discharge instructions and post-discharge telephone call.

- The combination of comprehensive discharge planning with post-discharge support reliably reduces readmissions, at least for one high-risk patient population: older patients with heart failure. This conclusion comes from a meta-analysis of 18 studies.\textsuperscript{30}

Elements of comprehensive discharge planning and post-discharge care and support believed to contribute to safer transitions from the hospital are reviewed below.

*Comprehensive discharge planning*

Patient-centered discharge planning is the recommended practice today. Though specific definitions of what this entails differ, descriptions consistently include the three elements shown below, and recommendations and successful models generally include at least one and often a bundle of the interventions shown for each element.\textsuperscript{31, 32, 33, 34, 35, 36, 37} What differs most from one program to another is which patients are targeted with intensive interventions (those with high-risk conditions such as CHF or more broadly defined groups) and what disciplines or specialists such as transition coaches are involved. Some programs have created a dedicated role for transition planning and support — the transition coach or advocate — usually played by a nurse.\textsuperscript{38, 39, 40, 41}
### Promising Components and Interventions — Comprehensive Discharge Planning

<table>
<thead>
<tr>
<th>Element</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assess Transition Risks</strong></td>
<td>• Screen patient for medical and social readmission risks</td>
</tr>
<tr>
<td></td>
<td>• Standardize risk assessment</td>
</tr>
<tr>
<td></td>
<td>• Query patient about prior post-discharge period</td>
</tr>
<tr>
<td></td>
<td>• Initiate planning to mitigate transition risks immediately</td>
</tr>
<tr>
<td></td>
<td>• Obtain information from primary and community care providers as needed</td>
</tr>
<tr>
<td><strong>Prepare the Patient</strong></td>
<td>• Identify the primary learner (may be family or other third party)</td>
</tr>
<tr>
<td></td>
<td>• Personalize education</td>
</tr>
<tr>
<td></td>
<td>• Teach patient regarding condition and recovery (self-monitoring, warning signs)</td>
</tr>
<tr>
<td></td>
<td>• Use teach-back to assess comprehension</td>
</tr>
<tr>
<td></td>
<td>• Provide patient-centered information to patient/family at discharge for reference (discharge instructions including plan of care, medications, appointments, contact information, etc.)</td>
</tr>
<tr>
<td></td>
<td>• Involve clinical pharmacist in pre-discharge education</td>
</tr>
<tr>
<td></td>
<td>• Utilize transition coaches/advocates</td>
</tr>
<tr>
<td></td>
<td>• Assess patient understanding of discharge plan of care</td>
</tr>
<tr>
<td><strong>Develop Post-Discharge Plan of Care</strong></td>
<td>• Involve all disciplines (nursing, social work, clinical pharmacist, etc.)</td>
</tr>
<tr>
<td></td>
<td>• Involve patient/family members</td>
</tr>
<tr>
<td></td>
<td>• Reconcile medications</td>
</tr>
<tr>
<td></td>
<td>• Incorporate care events and recovery milestones</td>
</tr>
<tr>
<td></td>
<td>• Counsel re: palliative and end-of-life care as appropriate</td>
</tr>
<tr>
<td></td>
<td>• Electronically prescribe discharge medications directly to community pharmacy</td>
</tr>
</tbody>
</table>

In parallel with work on readmissions, hospitals have been formalizing and standardizing the discharge process, including documentation and patient education. Much of this has occurred in response to the increased focus of the Joint Commission on the preparation for discharge as part of hospital accreditation. This has provided a process platform for all of the work on readmissions and undoubtedly helped with the improvements achieved in many hospitals so far.

**Post-discharge care and support**

Research findings have been clear on the importance of follow-up care and support for high-risk patients, even those with a comprehensive discharge plan, and there have now been demonstrations of several different models of organizing these interventions. Successful models include several interventions of each element listed below, though some programs target very high-risk patients exclusively and/or apply intensive interventions such as home visits selectively.

Providing post-discharge care and support is very resource-intensive. One of the biggest challenges is matching each discharged patient with the most effective set of interventions to provide care and support. Telephone outreach within some time period after discharge has become a common practice for most patients regardless of their risk profile and reason for admission, as well as actual scheduling of follow-up physician or clinic care before the patient is discharged.

### Promising Components and Interventions — Post-Discharge Support and Care

<table>
<thead>
<tr>
<th>Element</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prepare the Next Provider of Care</strong></td>
<td>• Identify next provider of care</td>
</tr>
<tr>
<td></td>
<td>• Standardize format and content of communication to next provider of care</td>
</tr>
<tr>
<td></td>
<td>• Assign responsibility for communication</td>
</tr>
<tr>
<td></td>
<td>• Communicate post-discharge plan of care and medication reconciliation</td>
</tr>
<tr>
<td></td>
<td>• Communicate discharge summary to physician responsible for follow-up care</td>
</tr>
<tr>
<td></td>
<td>• Use patient as conduit of information to next provider (paper communication, patient-managed personal health record)</td>
</tr>
<tr>
<td></td>
<td>• Confirm receipt by next provider of care</td>
</tr>
<tr>
<td></td>
<td>• Verify common understanding with telephone call to next provider of care</td>
</tr>
<tr>
<td></td>
<td>• Involve the patient’s physician in developing the discharge plan of care and home care</td>
</tr>
<tr>
<td></td>
<td>• Utilize a checklist for visits following discharge</td>
</tr>
</tbody>
</table>
Preventing Hospital Readmissions: The First Test Case for Continuity of Care

<table>
<thead>
<tr>
<th>Element</th>
<th>Intervention</th>
</tr>
</thead>
</table>
| Ensure Post-Discharge Follow-up | • Arrange care for patients lacking a regular source of care  
• Schedule appointments pre-discharge for follow-up clinician care and testing  
• Arrange home care/visiting nurse  
• Implement home-care protocols for high-risk patients  
• Front-load PCP/clinic visits  
• Front-load home care  
• Utilize APN with special training in population (CHF)  
• Provide transportation, free follow-up care (for uninsured)  
• Provide home visit(s) by nurse practitioner, physician, or multidisciplinary team  
• Verify visit and/or dispensing of discharge meds  
• Ensure provider continuity during the transition |
| Ensure Post-Discharge Support | • Provide post-discharge telephone outreach (NP or clinical pharmacist)  
• Engage in multiple telephone contacts  
• Provide patient hotline  
• Utilize transition coaches/advocates  
• Engage community services  
• Use telemonitoring with electronic link to case manager/provider to monitor status and compliance |

A seamless transition to the next provider of care requires that the physician practice or institution (such as rehab hospital or skilled nursing facility) be ready to receive the patient and that there be a common understanding of each patient's status, needs and treatment plan. Standardizing the format and content of information in the communication is one way of ensuring that all relevant information is included. Presumably communication will increasingly occur electronically, as both senders and recipients implement electronic health records (EHRs) with more advanced features including health information exchange.

Evolving Scope of Preventing Readmissions: Connection with Organized Care Management

Work on reducing readmissions started with a focus on a better discharge process and has evolved to include more care and support to patients following discharge.

The next phase of work to prevent readmissions will be to achieve a formal connection with organized care management for every patient covered by this type of program. There are several reasons that this is the next logical phase of work to reduce readmissions:

• Many of the patients being re-hospitalized are the 10% of the population that consume 80% of healthcare resources.49

• Some of these high-risk patients are already receiving ongoing support through care management programs of commercial health plans, Medicaid Advantage, Medicaid Managed Care or Global Payments programs, and special programs such as the Program of All Inclusive Care for the Elderly (PACE) that coordinates care and support for Medicare and Medicaid patients as an alternative to nursing home care.

• As pilot ACOs become operational, additional Medicare patients will receive the additional support of these programs, with more intensive support to high-risk patients. New programs for patients eligible for both Medicaid and Medicare ("dual eligibles") set to be launched in many states will also include intensive care management.
The transition from hospital care is distinct from organized care management, but can include many of the same interventions, as shown in the list of features of Medicare Coordinated Care Demonstration Programs that cut hospital admissions of high-risk patients. The best outcomes will be achieved when hospital-based efforts are combined with those of these external programs in close collaboration.

**Critical Elements of Connecting Readmission Prevention with Organized Care Management**

*Transitional care operated as a process in its own right*

<table>
<thead>
<tr>
<th>Definition of Transitional Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>A broad range of time-limited services designed to ensure health care continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another.</td>
</tr>
</tbody>
</table>

The hallmarks of transitional care are the focus on highly vulnerable, chronically ill patients throughout critical transitions in health and health care, the time-limited nature of services, and the emphasis on educating patients and family caregivers to address root causes of poor outcomes and avoid preventable hospitalizations.

There are systemic problems with the transition from hospital care, a time at which any patient is vulnerable. More patients than just those currently identified as high-risk can benefit from a smoother transition to avoid the anxiety of uncertainty about their recovery and possible visits to the emergency department. There are also opportunities to improve the transition of patients to admission with planned admissions. The scope of what must be done is bigger than can be achieved with further tweaking of the discharge process.

Transitional care needs to be elevated to a clinical process in its own right with clear accountability and formal processes, policies and procedures, including any new transition-focused roles, such as coaches. The organizational chart in many hospitals will show departments, such as social work and case management, as part of this new structure. Treating transitional care as a distinct process will also be critical to managing the complexity as more patients are subject to organized care management provided by a growing number of external programs. Hospitals that are part of integrated health systems are likely to have a system-wide transitional care process and will have the advantage of being able to link transition planning more easily with clinical partners, such as physician practices, nursing homes and health plans operated under the same corporate umbrella.

**Patient-specific transition pathways**

Those in the hospital responsible for transitional care will increasingly collaborate with external clinical partners with care management programs for both high-risk patients and patients more broadly to develop treatment plans, define mutually understood boundaries for care and support, and work within standard operating procedures for communication and hand-offs. For many patients there will be two external parties involved in the collaboration: the next provider of care (physician practice or SNF) and a care management program operated by a third party.

For every patient, the collaboratively developed transition plan will be structured as a clinical pathway with goals, milestones, treatment plan, care arrangements, monitoring checkpoints and scheduled communication updates and contacts to support coordination and close loops. How the pathway is modified when recovery goals are not met will also be spelled out. Transition pathways follow the model of hospital clinical pathways, but with additional elements laying out coordination points, communication modes and contact information.

As more patients are supported by organized care management, the biggest change for hospitals will be in the approach to planning and supporting transitional care. Over time, the hospital role in post-discharge activities will decline, but the timing of hand-offs for individual patients will range from immediate (at discharge) to much longer term depending upon the patient and external care management support or lack of it. For high-risk patients lacking external care management, the
hospital team will need the capacity to provide, or arrange for, intensive post-discharge services. The challenge will be to coordinate, not duplicate, care and support, but also ensure that every patient is supported and receives follow-up care.

**Health IT for patient tracking and collaborative care management**

Tracking patients will be essential to ensuring planned post-discharge care and support actually occurs in time to address gaps. This will only be possible with the assistance of health IT to accomplish communication and close loops.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Critical Health IT</th>
</tr>
</thead>
</table>
| Risk-minimizing Discharge | • Standardized assessments to capture risks  
                             • Ability to carry forward identified risks into discharge planning  
                             • Assistance with protocol-based discharge planning  
                             • Provision and documentation of tailored training  
                             • Medication reconciliation |
| Care and Support During the Transition | • Ability to directly arrange and schedule follow-up care at discharge  
                                            • eRx at discharge (dispensing feedback)  
                                            • Informing patient and family of plan of care, schedule and arrangements  
                                            • Informing next provider of care of plan of care, schedule and arrangements  
                                            • Tracking completion of transition milestones with aid of health IT (including outreach to patients) |
| Connection with Care Management | • Registry or other health IT linking patients with care management infrastructure  
                                 • Online access to up-to-date contact information for clinical partners  
                                 • Master Patient Index and Master Provider Index  
                                 • Health IT-enabled communication with clinical partners |

*Italicized items included in requirements for HITECH meaningful use.*

Another big contribution will be the availability of electronic templates as building blocks for patient transition pathways. Inputs will include condition-specific and risk-specific protocols, as well as jointly developed coordination points and hand-off procedures for each clinical partner that provides care management or follow-up care. For complex patients, the resulting pathway is likely to be unique. The complexity of the task of assembling and combining the relevant set of inputs will be much more manageable with electronic templates that lay out interventions and instructions for specified time periods of transition support.

Meaningful use for HITECH will provide the critical foundation of much more complete patient information available in the EHR and the basic infrastructure for communicating with clinical partners through health information exchange. Hospitals in health systems with integrated EHRs that cross inpatient and physician practice settings have a head start in creating the health IT needed to provide continuity of information during the transition from discharge.

**The First Test Case for Continuity of Care**

Why is reducing readmissions the first test case for continuity of care?

- For hospitals this is a big priority today. Not only are the financial stakes considerable, but extra attention to ensuring a smooth transition for every patient is also likely to be a good investment in the patient experience of care.
- As reimbursement shifts to ACOs and global payments, more institutions will be paying close attention to transitions in care. However, hospitals are on point already and have the burden of taking the lead.
- The collaboration, the process and the health IT infrastructure that will enable safe transitions from hospital care for more patients is similar to what’s needed for care management and continuity of care applied more globally.
- Organizations that build capacity for collaborative continuity of care will be better able to tackle the challenges of the future.

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