A Guide to Care Transitions: Navigating a Complex System
Coordination of care during care transitions plays a critical role in determining the quality of care. Centers for Medicare & Medicaid Services’ (CMS) beneficiaries receive. Healthcare involves a complex web of interactions that aims for everyone to achieve their maximum state of health and wellness. Care transitions and care coordination are essential processes where health systems, clinicians, community-based organizations, and other providers partner with people to help navigate the complex web of services across the continuum of care.
Definitions

To help ensure we are talking the same language, the CMS Care Transitions Post-Acute Care Affinity Group utilizes the following definitions to guide their work.

**Care transitions** is the transfer of care between members of the healthcare team, movement of an individual between levels of care, or the transfer from one setting of care to another, via seamless communication as the individual’s care needs change. Settings may include acute care, post-acute care, home, primary providers and specialists, the person’s community, and payers.

**Care Coordination** is a comprehensive and proactive approach that organizes an individual’s care activities and involves reassessment, frequent communication with the individual, and the sharing of information among participants involved with an individual's care. Care coordination may include various healthcare professionals as well as family members and caregivers. The individual’s needs and preferences are identified and communicated to provide individualized, comprehensive, safe, appropriate, and effective care.

**Case management** is the coordination and oversight of an individual’s health and wellness over the course of life, aimed to promote individualized, high quality, and cost-effective care; the process may include needs assessment, planning, facilitation, advocacy, counseling, service referrals, service authorization, and follow up.
A Call to Action

The Department of Health and Human Services (HHS) recognizes the importance of care transitions and the Federal agencies that reside within HHS have accomplished great work in this area. This represents CMS and Federal partner’s work to improve care transitions. These resources are by no means an inclusive list of all the great care transitions work that Federal agencies, partners, and other stakeholders have implemented.

This guide is intended to be used as a tool for users to better understand the available resources provided by federal agencies and CMS quality improvement partners, which will serve to assist in identifying how to do the following for the Medicare and Medicaid populations:

- Improve access to and utilization of community resources
- Decrease readmission rates
- Include methods of the community sharing best practices and resources among each other
- Outline Care transitions as a continuum of care
- Highlight the importance of transmitting and sharing data in care transitions

Some specific examples of how this document can be used include:

- Broaden and deepen awareness of care transition concepts
- Utilize the best practices as examples and inspiration to adopt within your own organization
- Share best practices, from this guide or your own best practices, with other partners and stakeholders
- Identify where your organization is in the adoption of care transition practices and aim for continuous improvement

Resource Topics

I. **Coordination of Care**

II. **Translations Between Settings**

III. **Hospital Readmissions**

IV. **Health Information Technology**
I. Coordination of Care

This section provides resources that are centered around coordination of care. Care transitions and care coordination play a critical role in determining the quality of care CMS’s beneficiaries receive. Healthcare is a complex web of interactions that aim for everyone to achieve their maximum state of health and wellness. Care transitions and care coordination are essential processes, which health systems and clinicians partner with individuals in helping people navigate this complex web across the continuum of care.

A. Strategies and Toolkits

1. AHRQ Coordination of care resources
   This website provides multiple tools and innovations that are aimed at improving care coordination for various populations.
   Link

2. AHRQ – Care Coordination Measures Atlas
   The Atlas aims to support the field of care coordination measurement by: Providing a list of existing measures of care coordination. Organizing those measures along two dimensions (domain and perspective) in order to facilitate selection of care coordination measures by Atlas users. Developing a framework for understanding care coordination measurement, incorporating elements from other proposed care coordination frameworks whenever possible.
   Link

3. AHRQ – Coordinated-Transitional Care Toolkit
   This tool kit, the “Coordinated-Transitional Care (C-TraC), is a low-resource, telephone-based, protocol-driven program designed to reduce 30-day rehospitalizations and to improve care transitions during the early posthospital period.”
   Link

4. TCPI Change Package: Transforming Clinical Practice (Section 1.5)
   This change package highlights a set of goals and the actions, or changes, that are needed to transform the clinical practice to meet the goals. It can serve as an inspiration in goal setting and tactics to achieving the established goals.
   Link
5. **Connected Care – Health Care Professional Toolkit**

This toolkit includes information for health care professionals, including tips for getting started, fact sheets on the requirements for implementing a chronic care management (CCM) program, and educational materials to share with patients.

[Link]

6. **Community Care Transitions Toolkit:**

“This toolkit will provide you with the information, resources, and tools you need to start your own care transitions initiative. Remember to think globally and act locally. You are encouraged to adjust resources as needed for your specific community.”

[Link]

### B. Reports and research

1. **AHRQ – Care Management: Implications for Medical Practice, Health Policy, and Health Services Research**

“This issue brief highlights three key strategies to enhance existing or emerging CM programs: (1) identify population(s) with modifiable risks; (2) align CM services to the needs of the population(s); and (3) identify, prepare, and integrate appropriate personnel to deliver the needed services.”

[Link]

### II. Transitioning Between Settings

This section provides resources geared to enhance transitioning between care settings. It is well known that “[i]mproving care transitions between care settings is critical to improving individuals’ quality of care and quality of life and their outcomes. Effective care transitions:

- Prevent medical errors and minimize risk
- Identify issues for early intervention
- Prevent unnecessary hospitalizations and readmissions
- Support consumers preferences and choices
- Avoid duplication of processes and efforts to more effectively utilize resources
- Reduce provider burden

[Link]
A. Strategies and toolkits

1. **ACL – Administration on Aging’s Presentation: Supporting Elders across Settings**
   This resource introduces care transitions themes and how they are linked to your mission, describe the Partnership for Patients and Community-based Care Transitions Program, and describes resources and technical assistance options. The audience is geared towards tribal organizations.

   [Link]

2. **CMS – The Accountable Health Communities Health-Related Social Needs Screening Tool**
   A screening tool, under evaluation, which helps identify if the individual needs help from community resources across 5 different domains: housing, food, transportation, utilities, and interpersonal safety.

   [Link]

3. **ACL – Evidence-Based Care Transitions Program**
   The 2010 Aging and Disability Resource Center (ADRC) Evidence Based Care Transitions program supports state efforts to significantly strengthen the role of ADRCs in implementing evidence-based care transition models that meaningfully engage older adults and individuals with disabilities (and their informal caregivers).

   [Link]

III. Hospital Readmissions

This section provides resources and information around hospital readmissions and methods of prevention. “Nearly one in five Medicare patients discharged from a hospital—approximately 2.6 million seniors—are readmitted within 30 days, at a cost of over $26 billion every year. Hospitals have traditionally served as the focal point of efforts to reduce readmissions by focusing on those components that they are directly responsible for, including the quality of care during the hospitalization and the discharge planning process. However, it is clear that there are multiple factors along the care continuum that impact readmissions and identifying the key drivers of readmissions for a hospital and its downstream providers is the first step towards implementing the appropriate interventions necessary for reducing readmissions.”
A. Strategies and toolkits
   1. Agency for Healthcare Research and Quality (AHRQ) – Re-Engineered Discharge (RED) Toolkit
      “A variety of forces are pushing hospitals to improve their discharge processes to reduce readmissions. Researchers at the Boston University Medical Center (BUMC) developed and tested the Re-Engineered Discharge (RED). Research showed that the RED was effective at reducing readmissions and posthospital emergency department (ED) visits.”
      Link 1
      Link 2

   2. AHRQ – Hospital guide to reducing Medicaid readmissions
      AHRQ commissioned this guide to identify ways evidence-based strategies to reduce readmissions can be adapted or expanded to better address the transitional care needs of the adult Medicaid population.
      Link

B. Reports and research
   1. Community-based Care Transitions Program (CCTP) – Success Stories of Hallmark Health System, Mystic Valley Elder Services, Somerville-Cambridge Elder Services and Cambridge Health Alliance
      This is a brief summary of how to reduce readmissions and prove a better experience for the patients in a high-risk, elderly population.
      Link

   2. Community-based Care Transitions Program (CCTP)
      This is the final report of the Evaluation of the Community-based Care Transitions Program, which highlights program implementation and follow up analysis findings.
      Link

IV. Health Information Technology
   This section provides information and resources on Health IT (HIT) and its role within care transitions. It’s important to consider the role of health IT in supporting care transitions.
because these tools can play an integral part in health information exchange and care coordination. Providers and consumers often use different forms of health IT such as EHRs, mobile apps, wearable technologies, patient portals, and health information exchanges to engage in care transitions and care coordination activities.

A. Strategies and Toolkits

1. Office of National Coordinators (ONC) Health IT Frequent Asked Questions (FAQ)

The following resources help the referenced stakeholders better understand, communicate, and utilize HIT to optimize care and outcomes.

   a) ONC FAQ – Consumers
      Link

   b) ONC FAQ – Providers
      Link

   c) ONC FAQ – IT Developers/vendors
      Link

2. ONC Health IT Playbook

The Health IT Playbook is a tool for administrators, physician practice owners, clinicians and practitioners, practice staff, and anyone who wants to leverage health IT. This resource has been extensively researched and gleaned from a variety of clinical settings to help end users find needed support.

Key topics include, but are not limited to:

- Sharing health information securely
- Engaging patients in their care
- Using health IT solutions to address the opioid epidemic
- Identifying health IT solutions that meet the needs of unique care settings and specialist

   Link

3. ONC Guide to Getting and Using Your Health Records

This guide was created by ONC to help users through the process of getting their health record. The resource shows how to make sure health
4. **Improving Medicare Post-Acute Care Transformation (IMPACT) Act**
The IMPACT Act requires the use of standardized Medicare quality measures and patient assessment data to be standardized and interoperable to allow for exchange of the data among post-acute care providers and other providers.

[Link](#)

5. **Data Element Library (DEL)**
The DEL is a centralized resource for CMS Post-Acute Care (PAC) assessment instrument data elements and their associated health information technology (IT) standards. The DEL is a tool that providers and their health IT vendors can use to support health information exchange from one provider to another and with patients and their caregivers.

a) **Webinar Introduction to the DEL**
[Link](#)

b) **DEL Overview**
[Link](#)

6. **States and Advancing Health IT**
CMS, in coordination with ONC, has created a series of toolkits and resources for Medicaid that are focused on health information exchange, health IT, and interoperability.

[Link](#)
Next Steps

Moving into Action...

What Are Your Next Steps?

CMS challenges you to evaluate your care transitions practices and commit to furthering the work to the next level, to improve how individuals move across care settings, with the aim of the individual remaining in his or her own community with maximal health and wellness.