The Importance Of Transitional Care In Achieving Health Reform

ABSTRACT Under the Affordable Care Act of 2010, a variety of transitional care programs and services have been established to improve quality and reduce costs. These programs help hospitalized patients with complex chronic conditions—often the most vulnerable—transfer in a safe and timely manner from one level of care to another or from one type of care setting to another. We conducted a systematic review of the research literature and summarized twenty-one randomized clinical trials of transitional care interventions targeting chronically ill adults. We identified nine interventions that demonstrated positive effects on measures related to hospital readmissions—a key focus of health reform. Most of the interventions led to reductions in readmissions through at least thirty days after discharge. Many of the successful interventions shared similar features, such as assigning a nurse as the clinical manager or leader of care and including in-person home visits to discharged patients. Based on these findings, we recommend several strategies to guide the implementation of transitional care under the Affordable Care Act, such as encouraging the adoption of the most effective interventions through such programs as the Community-Based Care Transitions Program and Medicare shared savings and payment bundling experiments.

More than a decade has passed since the Institute of Medicine published its landmark reports, To Err Is Human: Building a Safer Health System and Crossing the Quality Chasm: A New Health System for the 21st Century. Yet the quality of health care in the United States remains suboptimal and fragmented. These shortcomings particularly affect chronically ill people, who experience frequent changes in health status accompanied by multiple transitions between care settings and care providers.

Transitions, or “handoffs,” are vulnerable exchange points that contribute to unnecessarily high rates of health services use and health care spending, and they expose chronically ill people to lapses in quality and safety. It is during these transitions that mistakes commonly occur; for example, information about medication that a patient may have been prescribed while in the hospital may not be accurately communicated to the nursing home to which the patient is discharged. In addition to medication discrepancies, transitions can give rise to adverse clinical events; to patients’ having serious unmet needs; and to patients’ poor satisfaction with care. A recent multinational survey comparing the experiences of chronically ill adults from eight countries confirms these findings.

Transitions have also been associated with increased rates of potentially avoidable hospitalizations. A 2009 study reported that approximately 20 percent of Medicare beneficiaries discharged from hospitals were rehospitalized...
within thirty days and that 34 percent were re-admitted within ninety days. Nearly 13 percent of Medicare beneficiaries discharged from hospitals experienced three or more provider transfers during a thirty-day period. This “churning”—or movement of patients from hospitals to the community and back again—accounts for an estimated $15 billion in annual Medicare spending. To interrupt patterns of frequent use of health care services among the chronically ill and to address the negative effects on quality and costs, innovative solutions aimed at improving integration and continuity across episodes of care have emerged. Collectively, these solutions are referred to as “transitional care.”

Transitional care is defined as 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. Transitional care is complementary to but not the same as primary care, care coordination, discharge planning, disease management, or case management ( Exhibit 1 ). 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 rehospitalizations.

**The Affordable Care Act And Transitional Care**

Because of substantial opportunities for achieving higher-value health care—that is, reductions in spending without reductions in quality—by preventing avoidable hospital readmissions, transitional care programs emerged as a high priority under health reform.

Section 3026 of the Affordable Care Act of 2010, for example, establishes the Community-Based Care Transitions Program. The program provides $500 million from 2011 to 2015 to health systems and community organizations that provide at least one transitional care intervention to high-risk Medicare beneficiaries. Interventions may include initiation of services no

---

**EXHIBIT 1**

<table>
<thead>
<tr>
<th>Feature Of Transitional Versus Other Forms Of Care for Chronically Ill Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal</strong></td>
</tr>
<tr>
<td>Ensure health care continuity and avoid preventable poor outcomes</td>
</tr>
<tr>
<td><strong>Target Population</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Sources**


---

April 2011 30:4 Health Affairs 747
later than twenty-four hours prior to patients’ hospital discharges; timely postdischarge follow-up services to patients and their family caregivers; assistance to ensure productive and timely interactions between patients and postacute and outpatient providers; assessment and active engagement of patients and their family caregivers through self-management support; and comprehensive medication review and management.

The Affordable Care Act also supports transitional care services through a number of other vehicles. The Center for Medicare and Medicaid Innovation (Section 3021) offers an unprecedented opportunity to identify, evaluate, and disseminate innovative care delivery and payment models, including transitional care, through a $10 billion allocation for the period 2011–19. The Federal Coordinated Health Care Office (Section 2602) is designed to foster better integration of Medicare and Medicaid programs, improve care continuity, and ensure safe and effective care transitions for so-called dual eligibles—low-income elderly people or people with disabilities who are eligible for both Medicaid and Medicare.

Under the Medicare shared savings program (Section 3022), moreover, accountable care organizations will be required to submit performance data that may address care transitions across health care settings. Health homes (Section 2703) are designed to provide comprehensive care management, including transitional care, to people with chronic conditions. The national pilot program on payment bundling (Section 3023) will test an integrated, episode-based payment and care delivery model, including services such as transitional care.

Collectively, these and other provisions of the Affordable Care Act capitalize on transitional care as a way to rapidly achieve health reform’s goals. We evaluate how the available evidence on transitional care for chronically ill adults informs the implementation of these provisions.

**Study Data And Methods**

We conducted a systematic review to identify and synthesize available evidence regarding transitional care for adult, chronically ill populations. Combinations of key terms, including transitional care, readmissions, and patient discharge, were used to identify experimental studies of transitional care models and interventions—or reports of such studies in systematic reviews or meta-analyses—in PubMed and the Cumulative Index to Nursing and Allied Health Literature. Although no time limit was imposed, we excluded papers involving children or published in languages other than English.

This search yielded 587 articles. These were examined first at the title and abstract levels and then at the text level, only if the intervention met the definition of transitional care; targeted adults with at least one physical or emotional chronic disease; was initiated in response to an acute hospital or emergency department visit; and included postdischarge follow-up. Because our primary goal was to examine effective transitional care interventions within the context of health reform, we further refined our review to focus only on randomized clinical trials conducted in the United States. With the exception of one trial, in which the sample size was too small to permit rigorous comparisons of outcomes between the treatment and control groups, all other studies, including those with negative findings, were retained.

Ultimately, twenty-one articles were reviewed and compared using standard descriptors including aims, methods, and major findings. Because our review sought to inform implementation of the Affordable Care Act, we specifically examined each intervention’s effect on hospital readmissions and compared components of effective interventions to the law’s provisions. Significant and recurring findings were identified, as were potential implications for relevant Affordable Care Act provisions.

**Limitations**

The nature and practice of transitional care is evolving, and a standardized definition has not yet been established. The Affordable Care Act’s interpretation of transitional care is broad, so we chose to be inclusive in our search. Thus, the interventions retained in our synthesis are diverse and, in some cases, could reasonably be categorized in other ways (for example, as telehealth and case management interventions).

Our selection criteria probably resulted in the exclusion of some effective interventions. For example, we limited our review to randomized clinical trials in order to present a consistently high level of evidence. Because readmissions directly related to the diagnosis at the index (first) hospitalization account for only a relatively small proportion of all the reasons for rehospitalization among high-risk, chronically ill adults, we prioritized interventions that had effectively reduced all readmissions, whatever the cause. Furthermore, by limiting our study to interventions that were initiated in response to an acute hospital or emergency department visit, we excluded studies of effective transitional care models targeting patients transitioning from community-based or other settings.
Finally, important information about these interventions’ relevance to the Affordable Care Act may have been omitted from the publications we reviewed. For example, details about the degree to which these interventions incorporated self-management support, medication management, and use of health information technology may have been underreported in these articles and, therefore, in our synthesis.

**Study Results**

The twenty-one randomized clinical trials we reviewed focused on chronically ill adults transitioning from acute care hospitals to other settings, including patients’ homes or skilled nursing, rehabilitation, and long-term care facilities. Among these studies, there was substantial heterogeneity in the populations, settings, interventions, and methodologies. A summary of these studies and complete reference information is provided in the Appendix.24

For example, fourteen were single-site studies, and seven involved multiple sites. Of the twenty-one trials, three were conducted in Veterans Affairs health facilities. Patients were typically recruited from inpatient settings, although three studies recruited patients from emergency departments.25–27 Although all of the studies used a randomized clinical design, methodological rigor was uneven overall. For example, while the majority of studies used established individual patient randomization procedures, eight studies used block randomization—where treatment groups are randomized in blocks to keep the sizes of the groups similar—but this method can lead to selection bias. Sample sizes in a few studies were small and may not have been adequately powered to detect interventions’ effects.

**TARGET POPULATIONS** Among all of the studies, the mean sample size was 377 subjects (range: 88–1,396 subjects). Among the nine studies reporting these demographic data for the entire study sample, the mean age of the samples was 64.7 years (range: 32.7–76.0 years). With the exception of one study that recruited younger general medical patients with fewer co-existing conditions,28 all studies targeted high-risk patients who were elderly; were chronically ill with conditions such as congestive heart failure, asthma, diabetes, or depression; or had histories of multiple readmissions, or combinations of these. Diagnostic criteria were most often used to identify appropriate patients.

Eight studies focused on adults with heart disease—including heart failure, acute myocardial infarction, and angina—and two studies targeted psychiatric patients. Ten studies included family caregivers as secondary recipients of the study interventions. Services most frequently provided were assessing caregivers’ needs, social support, coping, strain, and skills; involving and seeking the participation of caregivers in patients’ care plans; providing caregiver education and counseling; preparing caregivers for patients’ discharges; and encouraging caregivers to take a more proactive role in patients’ care.

**NATURE OF THE INTERVENTIONS** The twenty-one interventions discussed in the articles we reviewed varied considerably in terms of their nature, point of initiation, intensity, and duration. The largest group could be characterized as comprehensive discharge planning and follow-up with (four studies) or without (three studies) home visits. The remainder dealt with disease or case management (four studies), coaching (two studies), education or psychoeducation (two studies), peer support (two studies), telehealth facilitation (one study), mobile crisis (one study), postdischarge geriatric assessment (one study), or intensive primary care (one study).

Fourteen of the twenty-one interventions were initiated in advance of patients’ hospital discharges, although the time was specified in only six studies (range: within 24 hours of admission to 24 hours prior to discharge). Twelve interventions included at least one postdischarge home visit as part of the protocol, and three studies incorporated in-person contact but not in patients’ homes (for example, during physician office or clinic visits). On average, postdischarge follow-up was initiated within three days of hospital discharge (range: 1–14 days).

Eighteen of the studies designated a nurse—most frequently, an advanced-practice registered nurse (ten studies)—as the intervention’s clinical manager or leader. Each of the remaining three studies relied on a nurse or social worker,29 a patient as a peer mentor,30 or personnel with experience in conducting clinical drug trials.26

**OUTCOMES** Collectively, a variety of primary and secondary outcomes in five categories were reported: health outcomes; quality of life; patient satisfaction or perception of care; resource use (including readmissions); and costs. Among these studies, the end point for assessment of the interventions’ effect ranged from one month to twelve months (mean, 5.4 months). Among the twenty-one studies, all but one31 reported positive findings in at least one category. The authors of five additional studies25,26,32–34 concluded that their interventions were largely ineffective based on the absence of positive findings on primary outcomes.

Because a key aim of the Affordable Care Act is
to reduce avoidable hospital readmissions, we were particularly interested in the nine interventions that reported a statistically significant positive effect on at least one measure of readmissions: total all-cause readmissions, time to first readmission, or length of readmission stay (Exhibit 2).

All but one of these nine studies reported reductions in all-cause readmissions through at least thirty days after discharge. Three of the remaining eight interventions found positive, long-term effects in all-cause readmissions through six months or twelve months following the index hospital discharge. These include two comprehensive discharge planning and follow-up interventions with home visits. One of the two demonstrated statistically significant reductions in rehospitalizations among patients hospitalized for common medical or surgical conditions through six months. The other reduced all-cause readmissions among hospitalized heart failure patients through twelve months.

The third telehealth-facilitated intervention, in which heart failure patients received either a videophone or telephone postdischarge support program, reported reduced all-cause readmissions through twelve months only when the two intervention groups were combined. There were no differences between the intervention group and the control group at three or six months. In the remaining five of eight studies reporting reduced all-cause readmission rates, effects were short-term, ranging from one to three months.

Across all nine studies that demonstrated a positive effect on at least one measure of readmissions, functional status and survival were among the most frequently measured health outcomes (Exhibit 3). Overall, few positive health effects were measured or demonstrated. Four of the five studies that each measured quality of life or patient satisfaction reported at least one positive effect.

Finally, the majority of these studies presented findings from economic analyses. However, the measures varied and typically did not incorporate additional costs of the intervention. If such costs were reported, often they did not include all relevant health services costs (for example, outpatient, home, and specialty care).

Only two studies accounted for costs of hospital readmissions, emergency department visits, unscheduled physician visits, visiting nurses and other health care personnel, and intervention costs. These two studies estimated a mean total cost savings of nearly $3,000 per Medicare beneficiary at six months and $5,000 at twelve months, respectively. Costs not included in these economic analyses were medications, supplies, and out-of-pocket patient expenses.

**RELEVANCE TO THE AFFORDABLE CARE ACT** In addition to examining the effectiveness of these

---

### EXHIBIT 2

#### Studies Demonstrating Positive Effects Of Transitional Care On Readmissions

<table>
<thead>
<tr>
<th>Citation</th>
<th>Intervention type</th>
<th>Measure of readmissions</th>
<th>Time to first readmission (no. of months)*</th>
<th>Length of readmission stay (no. of months)*</th>
<th>Other resource use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coleman et al., 2006</td>
<td>Coaching</td>
<td>• (3 mo)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daly et al., 2005</td>
<td>Disease/case management</td>
<td>NS</td>
<td>NS</td>
<td>(2 mo)*</td>
<td></td>
</tr>
<tr>
<td>Jack et al., 2009</td>
<td>Discharge management plus follow-up</td>
<td>• (1 mo)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naylor et al., 2004</td>
<td>Discharge management plus follow-up</td>
<td>• (12 mo)*</td>
<td>• (12 mo)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naylor et al., 1999</td>
<td>Discharge management plus follow-up</td>
<td>• (6 mo)*</td>
<td>• (6 mo)*</td>
<td>• (6 mo)</td>
<td>NS</td>
</tr>
<tr>
<td>Naylor et al., 1994</td>
<td>Discharge management plus follow-up</td>
<td>• (1.5 mo)*</td>
<td>NS</td>
<td>• (1.5 mo)*</td>
<td>NS</td>
</tr>
<tr>
<td>Parry et al., 2009</td>
<td>Coaching</td>
<td>• (3 mo)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rich et al., 1995</td>
<td>Discharge management plus follow-up</td>
<td>• (3 mo)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wakefield et al., 2008</td>
<td>Telehealth</td>
<td>• (12 mo)*</td>
<td>• (12 mo)*</td>
<td></td>
<td>NS</td>
</tr>
</tbody>
</table>

**SOURCE** Authors’ synthesis of evidence reviewed. Full citation information for the nine studies is available in the Appendix. See Note 24 in text. **NOTES** Bullets indicate a statistically significant positive effect (p ≤ 0.05). NS is not significant. *Effect persists after discharge, in months. †Intervention protocol includes home visit. ‡Also measured index-related readmission rates but excluded from this analysis. §No measure is reported. ‡Defined as the total number of emergency department visits and readmissions per participant within thirty days of index discharge. ‣Study measured time to first readmission or death. ․Medical patients only. †All patients combined.
interventions, we explored how this body of evidence informs the implementation of transitional care provisions in the Affordable Care Act. Although studies focused primarily on high-risk, chronically ill patients, none of the reviewed interventions targeted dual eligibles, cognitively impaired, or medically underserved populations. Yet these vulnerable groups are among the intended beneficiaries of transitional care under the Affordable Care Act.

Additionally, none of the interventions is a complete match to the multiple components of this law (Exhibit 4). In particular, two components—use of health information technology and coordination of community resources—are commonly absent from these reported interventions.

**INSIGHTS FROM REVIEW** Despite these gaps, some critical insights and meaningful patterns emerge from among these effective interventions. Based on our review, we conclude that there is a robust body of evidence substantiating the benefits of transitional care. Studies of nine interventions demonstrated a positive effect on at least one measure of readmissions; eight of the nine reduced all-cause readmissions through at least thirty days after discharge. Among these nine interventions, the average length of the postdischarge portion was six and a half weeks. However, three more effective interventions, which demonstrated reductions in readmissions

### Exhibit 3

**Other Outcomes: Studies Of Effective Interventions In Transitional Care**

<table>
<thead>
<tr>
<th>Citation</th>
<th>Intervention type</th>
<th>Health</th>
<th>Quality of life</th>
<th>Patient satisfaction</th>
<th>Cost-effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coleman et al., 2006</td>
<td>Coaching*</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Daly et al., 2005</td>
<td>Disease/case management*</td>
<td>NS</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Jack et al., 2009</td>
<td>Discharge management plus follow-up</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Naylor et al., 2004</td>
<td>Discharge management plus follow-up*</td>
<td>NS</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Naylor et al., 1999</td>
<td>Discharge management plus follow-up*</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>•</td>
</tr>
<tr>
<td>Naylor et al., 1994</td>
<td>Discharge management plus follow-up*</td>
<td>NS</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Parry et al., 2009</td>
<td>Coaching*</td>
<td>NS</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Rich et al., 1995</td>
<td>Discharge management plus follow-up*</td>
<td>NS</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Wakefield et al., 2008</td>
<td>Telehealth</td>
<td>NS</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
</tbody>
</table>

**Source** Authors’ synthesis of evidence reviewed. Full citation information for the nine studies is available in the Appendix. See Note 24 in text. **Notes** Bullets indicate a statistically significant positive effect (p < 0.05). NS is not significant. *Intervention protocol includes home visit. *No measure is reported. *Economic analysis accounts for total health care costs (that is, hospital readmissions, emergency department visits, unscheduled acute care visits to physicians, and home care) while also accounting for the costs of the intervention. *Medical patients only. *Analysis for a subgroup of the sample.

### Exhibit 4

**Relevance Of Affordable Care Act Intervention Components To Studies Of Effective Transitional Care Interventions**

<table>
<thead>
<tr>
<th>Intervention component</th>
<th>Postdischarge follow-up</th>
<th>Comprehensive assessments, care planning</th>
<th>Interactions with postacute, outpatient providers</th>
<th>Coordination/ referrals for community resources, supports</th>
<th>Self-management support</th>
<th>Comprehensive medication review, management</th>
<th>Use of health IT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coleman et al., 2006</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Daly et al., 2005</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Jack et al., 2009</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Naylor et al., 2004</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Naylor et al., 1999</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Naylor et al., 1994</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Parry et al., 2009</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Rich et al., 1995</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Wakefield et al., 2008</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
</tbody>
</table>

**Source** Author’s synthesis of evidence reviewed. Full citation information for the nine studies is available in the Appendix. See Note 24 in text. **Notes** Intervention types are listed in Exhibits 2 and 3. IT is information technology. *Component of Community-Based Transitions Program. *No measure is reported. *Care planning only.
through six or twelve months, averaged more than nine weeks postdischarge in length. All nine interventions that showed any positive impact on readmissions relied on nurses as the clinical leader or manager of care.

Six of the nine studies that demonstrated a positive effect on at least one measure of readmissions included in-person home visits. Two types of multicomponent interventions have proved more effective in reducing all-cause readmissions: comprehensive discharge planning with follow-up interventions that incorporate patient and caregiver goal setting, individualized care planning, educational and behavioral strategies, and clinical management, and a telehealth-facilitated intervention emphasizing daily home videophone or telephone monitoring and transmission of physiologic measurements, self-care instruction, and symptom management. The Agency for Healthcare Research and Quality and the National Quality Forum have highlighted these and other transitional care interventions as innovations and preferred practices.

Each of the three studies that effectively reduced readmissions through at least six or twelve months after discharge included a focus on patient self-management. They also examined interventions that proactively connected acute care providers with primary care physicians and other providers to forestall any problems coming from handoffs.

Policy Implications
Our review offers important insights into the delivery of effective transitional care and informs policies developed under the Affordable Care Act. We offer recommendations intended to promote the adoption of effective interventions, foster transparency and accountability, and strengthen the health care workforce in its delivery of these interventions.

**ADOPT EFFECTIVE INTERVENTIONS** Federal law is now focused on reducing thirty-day readmissions for specific conditions such as heart failure, pneumonia, and acute myocardial infarction. However, our review highlights interventions that have achieved positive impact through six or twelve months after the index hospital discharge among even more diverse patient populations and, thus, offer opportunities to achieve longer-term, higher-value health care. Furthermore, the range of effective interventions and their relative effects suggest opportunities to customize interventions based on patients’ needs and care delivery limitations.

To this end, we support the following goals, which would expand the current system by adding resources and interventions. These goals are supported by evidence and can be tailored and targeted to meet individual needs.

**GOAL ONE:** Interventions selected for implementation should be identified based on their known effectiveness in achieving established performance improvement goals and objectives. Priority should be placed on the small subset of more effective interventions that contribute to reductions in readmissions for all causes through twelve months, compared to the larger number of interventions that reduced readmission rates through only thirty days. To recap, these more effective interventions included ones that provided comprehensive discharge planning and home follow-up or telehealth-facilitated monitoring postdischarge support.

**GOAL TWO:** Investments should be made to promote the endorsement and widespread adoption of effective interventions as best practices by public and private organizations, accrediting bodies, and government agencies such as the National Quality Forum, Joint Commission, Agency for Healthcare Research and Quality, and Centers for Medicare and Medicaid Services.

**GOAL THREE:** Adoption of these models over less effective interventions should be incentivized under programs established in the Affordable Care Act. For example, eligible entities submitting proposals to the Department of Health and Human Services to participate in the Community-Based Care Transitions Program under Section 3026 should be encouraged to adopt or adapt from among these effective interventions noted above in Goal One. The Department of Health and Human Services should provide further incentives for the selection of these interventions through programs such as Medicare shared savings and payment bundling.

**GOAL FOUR:** Ongoing investments should be made to determine which interventions are adaptable to other high-risk beneficiaries defined in the Affordable Care Act, such as the cognitively impaired and dual eligibles, without diminishing the interventions’ positive effects or jeopardizing their feasibility.

**TRANSPARENCY AND ACCOUNTABILITY** To date, great progress has been made in establishing a health care performance measurement, public reporting, and performance-based incentive infrastructure. The National Quality Forum’s identification and endorsement of performance measures that address care coordination, including transitional care, is evidence of this progress.

To accelerate, strengthen, and expand on what already exists, the development of additional, scientifically sound measures that address the full range of transitional care processes and outcomes should be a priority. The effective inter-
We have identified three proven strategies that have reduced all-cause readmissions through six or twelve months.

In January 2011 the first provisions of the Affordable Care Act began to be implemented. For many of the innovations the act promotes, there is little available science to inform implementation. For transitional care, however, this is clearly not the case. Our evidence review reveals nearly a dozen interventions that have demonstrated some positive affect on hospital readmissions. More critically, we have identified three proven strategies that have effectively reduced all-cause readmissions through six or twelve months. Based on the major opportunity for improvement and the potential human and economic benefits, we recommend that these strategies serve as prototypes to guide the implementation of transitional care under the Affordable Care Act.

Conclusion

In January 2011 the first provisions of the Affordable Care Act began to be implemented. For many of the innovations the act promotes, there is little available science to inform implementation. For transitional care, however, this is clearly not the case. Our evidence review reveals nearly a dozen interventions that have demonstrated some positive affect on hospital readmissions. More critically, we have identified three proven strategies that have effectively reduced all-cause readmissions through six or twelve months. Based on the major opportunity for improvement and the potential human and economic benefits, we recommend that these strategies serve as prototypes to guide the implementation of transitional care under the Affordable Care Act.

Support for this article was provided by the Robert Wood Johnson Foundation.

NOTES

14 National Priorities Partnership. National priorities and goals: aligning our efforts to transform America’s healthcare. Washington (DC):
24 To access the Appendix, click on the Appendix link in the box to the right of the article online.
26 Currier GW, Fisher SG, Caine ED. Mobile crisis intervention to enhance linkage of discharged suicidal emergency department patients to outpatient psychiatric services: a randomized controlled trial. Acad Emerg Med. 2010;17(1):36–43.