CMS Announces National Partnership to Improve Care and Lower Cost

Improving the process by which an individual moves from the hospital back to the home or another care setting, also known as care transitions, is critical to create a more person-centered, cost-effective health care system. National statistics report that 18 percent of individuals return to the hospital within 30 days of a hospital discharge, with up to 76 percent of these readmissions being preventable. Further, Medicare data show that over half of older and disabled individuals who are readmitted to the hospital received no care or follow-up in the 30 day window.

The latest installment of Health Affairs' new series *The Care Span,* supported by The SCAN Foundation, identifies several ways to strengthen transitional care processes through health reform provisions. Titled, "**The Importance Of Transitional Care In Achieving Health Reform**," Dr. Mary Naylor and colleagues identified nine different interventions that specifically decrease hospital readmissions thus improving patient outcomes and reducing unnecessary health care expenditures. These interventions target key problems faced by patients, families and providers at a time of significant risk: discharge from an acute care hospital. **The article is available on The SCAN Foundation Web site free of charge.**

A perfect example of problems that care transition interventions seek to address are medical errors that can occur when multiple "cooks" (the older person, their family, and a myriad of health and supportive service providers) are in the proverbial health care "kitchen." Medical errors, such as adverse drug reactions and health care acquired infections, lead to substantial human and financial costs, which affect thousands of lives each year.

To this end, Health and Human Services (HHS) **Secretary Kathleen Sebelius announced** Tuesday the ***Partnership for Patients***, a new national collaboration between the Obama administration, the private sector, hospitals and doctors to improve care and lower costs for Americans. HHS launched the partnership by announcing it would invest up to $1 billion to implement two key provisions in the Affordable Care Act: the Community-based Care Transitions Program and demonstrations to reduce hospital-acquired conditions through the CMS Innovation Center.

Investments will be made in reforms that achieve two critical goals:

- **Preventing hospitalized individuals from getting injured or sicker.** By the end of 2013, preventable hospital acquired conditions would decrease by 40-percent compared to 2010.

- **Helping individuals heal and transition across care settings without complications.** By the end of 2013, preventable complications during a transition from one care setting to

another would be decreased so that all hospital readmissions would be reduced by 20 percent compared to 2010.

Community-based organizations and partnering acute care hospitals can submit applications for this funding. For more information on the Partnership, please visit the **HHS Web site**.