In its landmark 2001 *Crossing the Chasm* report, the Institute of Medicine described the health care system as poorly organized, with “layers of processes and handoffs that patients and families find bewildering and clinicians view as wasteful.” Despite the impressive gains that many hospitals and health systems have made since the report was issued over a decade ago, the health care system at large has struggled to tackle the problems of costly errors; lack of coordination among providers; and poor care transitions as patients move from one setting to the next, such as being discharged from the hospital and returning home. Taken together, the costs related to hospital errors, inadequate care transitions and avoidable hospital readmissions are staggering.

- In 2011, inadequate care coordination—including mismanagement of care transitions from one setting to another—resulted in $25 billion to $45 billion in wasteful spending, according to a 2012 *Health Affairs* policy brief. At the heart of the problem are costly and dangerous complications and unnecessary hospital readmissions that could be prevented through improved patient education and exchange of information between multiple providers.

- Once discharged from the hospital, nearly one in five Medicare patients—or 2.6 million seniors—is readmitted to the hospital within 30 days, costing the federal government approximately $26 billion annually. About three-quarters of these readmissions could be prevented through improved care transitions, offering an estimated $12 billion in savings each year.

- According to a 2010 Office of the Inspector General report, one in seven of the nearly 1 million Medicare beneficiaries discharged from hospitals in October 2008 experienced harm as a result of medical care or in a health care setting. About 45 percent of these “adverse events” were preventable.

Despite the dire news, leading hospitals and health systems, as well as public and private payers, are changing the trajectory by implementing innovative solutions aimed at reducing errors and keeping patients healthy after they leave the hospital. Pointing to “pockets of excellence” throughout the country, U.S. Health and Human Services (HHS) Secretary Kathleen Sebelius wrote in 2012 that “hospitals across the country are showing that delivering better care is possible.”

To promote best practices on a national scale, the Affordable Care Act (ACA) provides funding to address the root causes of hospital-acquired conditions and avoidable hospital readmissions. The nationwide initiative, known as the Partnership for Patients (Partnership), aims to reduce health care-acquired conditions by 40 percent and decrease preventable hospital readmissions by 20 percent by the end of 2013 (compared to the incidence in 2010). This is expected to decrease preventable complications for 1.6 million patients. Partnership strategies include development of resources and training support packages for hospitals, including approximately 2,000 rural hospitals in the United States, almost two-thirds of which have 50 or fewer beds. In August 2011, the federal Office of Rural Health Policy convened a meeting of rural experts and federal officials to explore implementation of the Partnership in rural settings. Results included recommendations on providing technical assistance and support to rural communities participating in the Partnership. A Partnership Rural Affinity Group was established to address specific issues and strategies specific to rural areas.

State policymakers, many with rural constituents, have a significant stake in implementing systemic payment reforms.
that improve care and reduce costs. This brief describes the various components of this massive public-private partnership and offers state options for engaging with the initiative.

**Partnership Overview**

To date, more than 8,000 partners—including about 3,700 hospitals, as well as physicians’ and nurses’ groups, consumer groups, employers, Area Agencies on Aging, and state and federal health officials—have joined the Partnership for Patients. 

Partners agree to implement best practices to improve patient safety and reduce complications related to hospitalizations. Participants have access to Partnership resources and tools, collaborative learning, and technical assistance to help them implement evidence-based practices and policies.

**Key Initiatives**

The Partnership aims to achieve its goals through three major initiatives, including Hospital Engagement Networks, the Community-Based Care Transitions Program, and patient and family engagement. The Partnership focuses on improving care and reducing errors in 10 core patient safety focus areas (see box).

### Patient Safety Focus Areas

The Partnership identified 10 core patient safety areas of focus:

1. Adverse drug events
2. Catheter-associated urinary tract infections
3. Central line-associated blood stream infections
4. Injuries from falls and immobility
5. Obstetrical adverse events
6. Pressure ulcers
7. Surgical site infections
8. Venous thromboembolism
9. Ventilator-associated pneumonia
10. Readmissions

*Source:* CMS.gov, Partnership for Patient website.

**Hospital Engagement Networks**

In December 2011, HHS awarded nearly $218 million in grants to help 26 state, regional, national or hospital system organizations become Hospital Engagement Networks. These entities—comprised largely of state hospital and health care associations—develop learning collaboratives for the 3,700 participating hospitals and provide training and improvement skills to improve patient safety. According to HHS, Hospital Engagement Networks serve as “mobile classrooms” by sharing lessons learned and best practices with hospitals in the region. Hospital improvement teams that focus on reducing adverse childbirth events, for example, can benefit from the successes and lessons learned from other hospitals that have addressed the same issues. They also provide technical assistance to help hospitals implement a system to track and monitor progress toward meeting quality improvement goals.

**Improving Care Transitions**

Ensuring a smooth transition between care settings—e.g., hospitals, home health care agencies, outpatient settings and post-acute facilities—is a crucial strategy for improving health outcomes and reducing unnecessary hospitalizations. As patients move from one health care provider or setting to another, they may be subject to medical errors or breakdowns in communication between providers. Safe transitions require patient and provider engagement, person-centered care plans that move across settings, accurate exchange of information between providers, and safe medication practices, among other best practices.

Several barriers impede a safe and seamless transition. According to the 2012 *Health Affairs* report, “One of the biggest barriers to smoother care transitions is the fact that primary care physicians often have little or no information about their patients’ hospitalizations.” In fact, just 12 percent to 34 percent of physicians received their patient’s discharge summaries, according to a 2007 *Journal of American Medical Association* review. Other factors that contribute to hospital readmissions include payment policies that do not offer incentives for smooth care transitions, poor quality of care, premature hospital discharges or discharges to the wrong setting, and lack of patient information and follow-up.

*Source:* CMS.gov, Partnership for Patient website.
To address these issues, section 3026 of the Affordable Care Act authorized funding to test models for improving care transitions for high-risk Medicare patients. In April 2011, the Centers for Medicare and Medicaid Services (CMS) announced funding for the Community-Based Care Transitions Program. The funding allows a community of providers to design and propose a Medicare fee-for-service benefit to receive payment for care transitions for high-risk Medicare enrollees. Eligible applicants include acute care hospitals with high readmission rates in partnership with a community-based organization that provides care transition services (see box).

To date, 82 community-based organizations participate in the Community-Based Care Transitions Program. Organizations submit monthly invoices to CMS for care transition services. CMS pays organizations an all-inclusive, per-patient rate to cover the cost of care transition services provided in the 180 days following the patient’s discharge from the hospital, as well as the cost of systemic changes made by the partner hospital. Unlike other grant programs, recipients do not receive payments for administrative or infrastructure costs. The participants are awarded two-year agreements that may be extended annually through the duration of the program, based on performance. CMS gives preference to Administration on Aging (AoA) grantees that partner with multiple hospitals and providers that serve medically underserved populations, small communities and rural areas.16

**Community-Based Care Transition Program Eligibility**

Eligible applicants must demonstrate a partnership between:

- Acute care hospitals with high readmission rates, and
- Community-based organizations that provide care transition services across the continuum of care.

Applicants that provide services to medically underserved populations, small communities and rural communities receive preference.

Source: CMS, CCTP website.

**Patient and Family Engagement**

Architects of the Partnership believe that patients and their families are essential partners in improving the safety and quality of health care. To that end, the Partnership leverages the existing tools and resources that currently are used by hospitals and health care facilities, as well as identifying and disseminating best practices to the members of the Hospital Engagement Network. According to the CMS, “Robust efforts to engage patients and families in their care are woven throughout all aspects of the Partnership for Patients to achieve system-wide adoption of patient and family engagement best practices.”

**State Actions**

The federal Partnership aligns with existing state efforts to improve quality and reduce costs in state Medicaid programs. Because Medicaid consumes a significant share of state budgets—in 2011, states spent nearly 17 percent of their general funds on Medicaid, second only to elementary and secondary education17—states across the nation are adopting payment and care delivery innovations to reduce costs while improving health outcomes. As with the federal Partnership for Patients initiative, states are pursuing these goals through a mix of delivery and payment policies that give providers incentives to deliver high-quality, patient-centered, coordinated care. A brief summary follows of state-led reforms that complement and support the federal initiative.

**Connecting the Dots between State Activities and the Partnership**

States can engage with the Partnership in various ways, from actively participating as a Partnership member, to ensuring that state Medicaid programs are engaged in their own initiatives to improve patient safety. Several states—including Arizona, Arkansas, Colorado, Delaware, Florida and New York—participate in the Partnership. States that participate agree to use market-based incentives (e.g., align payment to promote improvements in safety); work with other private payers, states and the federal government to align quality and safety measures; and share information with other members to promote overall goals. Participation in the Partnership, therefore, offers an opportunity to accelerate innovations already occurring at the state level.

In addition, since many hospitals, providers and state agencies are actively participating in the Partnership, state leaders can learn from their experiences and exchange information about best practices within the Partnership framework. Working toward a common vision, the initiatives rely on the same stakeholders—e.g., hospitals, providers, state Medicaid agencies, insurers and consumers—to improve care quality while reducing health care costs.

"Medicaid's role as a large payer for traditional health care, as well as its importance in long-term care, necessitates Medicaid participation and leadership in system reform efforts. That role has already expanded with recent program growth, and will grow more in states choosing to expand their eligibility in 2014 and beyond. In this context, Medicaid agencies across the country are examining all of their possible levers to affect change, including collaborative efforts with other stakeholders."

—National Association of Medicaid Directors, February 2013
State-Based Care Delivery and Payment Reforms That Align with the Partnership Mission

States are adopting a wide array of payment and delivery system reforms to improve quality and reduce costs. These include payment policies, quality improvement and oversight initiatives, systems accountability and care coordination strategies.

Payment Reforms. States are adopting payment policies that offer incentives for quality and efficiency and/or disincentives for ineffective care or uncontrolled costs. Rather than paying providers for each individual service or procedure, for example, bundled payments provide a single payment for all services—e.g., tests, office visits and hospitalizations—associated with an episode of care. By bundling payments into one episode-based payment, providers have incentives to provide efficient and appropriate services, coordinate care among all health care providers, and achieve positive health outcomes. The Arkansas Medicaid Payment Improvement Initiative offers episode-based payments for certain medical conditions, such as upper respiratory infections, perinatal care and congestive heart failure.

State payment policies reinforce the Partnership’s goals of reducing preventable hospital-acquired conditions and readmissions through nonpayment or reduced payment for preventable adverse incidents and errors. The ACA prohibits the federal government from providing payments to states for health-care-acquired conditions and other provider-preventable conditions as of July 2012. According to a survey by the Center for Medicaid and State Operations, 21 state Medicaid programs already had nonpayment policies for health-care-acquired conditions in place in 2011. 18

Quality Improvement and Oversight. According to a 2013 report by the National Association of Medicaid Directors, “Value-based purchasing is the watchword of modern Medicaid.” 19 Developing quality and cost data collection and reporting capabilities enables agencies to assess value and monitor progress toward quality improvement goals. Several states have adopted strategies that pay providers for high performance and value. Pay-for-performance models offer incentives for providers to deliver timely, cost-effective care—especially preventive and chronic care. The Massachusetts Medicaid’s hospital-based program, for example, provides incentive payments to hospitals based on each institution’s score for a set of quality indicators related to pneumonia care and surgical infection prevention. Minnesota implemented a payment system that rewards high-quality, low-cost health care providers. The state Medicaid program and state employee health plan also partner with private sector employers in a statewide pay-for-performance program.

In addition to payment and delivery reforms, states also are adopting patient safety initiatives that align with the federal initiative’s focus on improving care and reducing errors in the 10 core patient safety focus areas, including adverse drug events, fall prevention, surgical site infections and childbirth complications (see page 2 for full list). In 2012, for example, New York and Washington appropriated or designated funds to address prevention of older adult falls, while the Massachusetts legislature amended the structure of the existing fall prevention commission. Prior to 2012, at least eight states enacted legislation to create fall prevention programs or require other older adult fall prevention activities.

Managed Care and Systems Accountability. States have adopted models such as managed care to provide financial incentives for better and more efficient care. Between 2012 and 2013, the Kaiser Commission on Medicaid and the Uninsured found that 40 states were adopting new Medicaid managed care policies, mainly by expanding into new areas or adding new eligibility groups. 20 Key objectives of Medicaid managed care include improved health plan performance, health care quality and health outcomes.

Care Coordination and Medical Homes. States are implementing targeted strategies to encourage high-value care through coordinated care models, such as medical homes or health homes. The medical home model provides comprehensive, patient-centered preventive and primary care through a team of providers and across health care settings to help smooth transitions and reduce readmissions. By coordinating care and services among a patient’s care team, health homes offer an important tool for improving care and results, while also reducing costs related to poor coordination and lack of communication among disparate providers. As of January 2012, policies in 41 states promote the medical home model for certain Medicaid or Children’s Health Insurance Program beneficiaries. 21
### Partnership Resources for States and Other Members

<table>
<thead>
<tr>
<th>Entity/Initiative</th>
<th>Description</th>
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<tbody>
<tr>
<td>Hospital Engagement Networks</td>
<td>Hospital Engagement Networks offer one strategy for implementing evidence-based innovations in hospitals and medical practices.</td>
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<tr>
<td>CMS Innovation Center/ National Level Resources and Training</td>
<td>To help support the work of the Hospital Engagement Networks in reducing hospital-acquired conditions and readmissions, the CMS Innovation Center is providing technical assistance and training materials. The aim of these efforts is to “enable each HEN to rapidly move its hospital network to support the Partnership for Patient’s goals.” These resources are widely available and may offer new sources of funding and/or technical assistance to hospitals and other delivery systems.</td>
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<tr>
<td>Quality Improvement Organizations</td>
<td>CMS contracts with Quality Improvement Organizations (QIO) in every state to: “improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries.” QIOs can provide technical assistance and data analysis to eligible organizations that want to apply for the Medicare Community-Based Care Transitions Program.</td>
</tr>
<tr>
<td>Specialized Learning Collaboratives and Affinity Groups</td>
<td>By targeting efforts in the Partnership’s 10 core patient safety focus areas, member organizations can adopt practices that improve health outcomes and reduce complications for high-risk populations. Specialized learning communities, such as the Rural Health Affinity group, provide access to resources for rural communities and critical access hospitals. Other affinity groups focus on improving maternal outcomes, reducing adverse drug events and preventing inappropriate readmissions.</td>
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<tr>
<td>National Priorities Partnership</td>
<td>The National Quality Forum convened the National Priorities Partnership (NPP), which brings together leaders from 52 stakeholder organizations, including federal agencies, national associations (e.g., America’s Health Insurance Plans, American Medical Association), consumers, purchasers, providers and others. The goal is to help organizations nationwide “start and sustain changes that will lead to reduced health care-caused harm and cost.” NPP convened action teams to address maternity care and hospital readmissions, and it offers a wide range of learning opportunities through patient safety webinars, online registries, case studies and other tools.</td>
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## Conclusion

The Partnership for Patients provides a framework for testing models of care and sharing best practices among a nationwide partnership of public and private stakeholders. As states look for opportunities to reduce health care costs and improve quality of care and patient safety, they will benefit from the growing portfolio of training materials, lessons learned and strategic partnerships aimed at improving patient safety and reducing unnecessary hospital readmissions. As described in this brief, states can choose from a wide variety of opportunities to engage with other partners to accelerate change and achieve the goals of saving lives, improving health care delivery and outcomes, and reducing health care costs.

## Rural Opportunities

The Partnership offers several educational and collaborative opportunities for rural communities and providers. Rural hospitals are already connecting with the Partnership; at least half of all Critical Access Hospitals or rural hospitals are affiliated with a Hospital Engagement Network, which provides technical assistance, best practices and learning opportunities for all hospitals. Many Hospital Engagement Networks also participate in the Rural Health Affinity Group, a peer community that shares best practices and lessons learned from rural hospitals, and offers educational events and resources that address rural challenges and opportunities.

The Rural Health Affinity Group has coordinated with the organization that is developing and adapting materials and methods for the Partnership, to identify and engage high-performing hospitals to share their progress and best practices. Through meetings and information-sharing, the group promotes a culture of safety and leadership to address the Partnership’s 10 core patient safety focus areas. The group focuses on identifying solutions for common patient safety issues in rural hospitals. In addition to disseminating information from the Hospital Engagement Networks to rural hospitals, the Rural Affinity Group also educates Hospital Engagement Networks on the unique challenges and needs shared by rural hospitals.
For More Information/Resources
Partnership for Patients website  

Community-based Care Transitions Program  

Improving Patient Safety and  
Hospital Engagement Networks  

Hospital Engagement Network Resources and Tools  
http://hret-hen.org/

Quality Improvement Organizations  
www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment- 
Instruments/QualityImprovementOrgs/Current.html

National Priorities Partnership  

Notes
8. A list of the 26 Hospital Engagement Networks is available online at www.healthcare.gov/compare/partnership-for-patients/safety/index.html.
13. Ibid.  
14. Ibid.  
Instruments/QualityImprovementOrgs/index.html?redirect=//qualityimprovementorgs/