

Special Report: Discharge Planning, Care Transitions, and
Hospital Readmissions

Landscape

Part 2 | October 2024

Prepared by Livanta LLC

Beneficiary and Family Centered Care – Quality Improvement
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Executive Summary

Livanta's Landscape report series focuses on Medicare beneficiaries' rights to high-quality health care. As a Beneficiary and Family Centered Care – Quality Improvement Organization (BFCC-QIO), Livanta has pledged to help educate the public and industry groups about Medicare rights and the role of the BFCC-QIO Program. This Landscape report is an example of that pledge.

As the second report in the series, **Landscape Part 2** reviews the critical topics of discharge planning, transitions of care, and hospital readmissions. Other reports in the Landscape series are described below. Click the following link to download any of the Landscape reports: <https://www.LivantaQIO.cms.gov/en/About/Publications>.

The intent of the Landscape report series is to broaden the knowledge of critical topics for Medicare stakeholders and healthcare partners. Livanta is pleased to present this report to the Centers for Medicare & Medicaid Services (CMS) and other interested parties to help further the collective knowledge of Medicare rights and the BFCC-QIO Program.

- **Landscape Part 1** describes the rights and protections Medicare beneficiaries are afforded under the BFCC-QIO Program. This report also describes many aspects of high-quality health care and Livanta's role as a Medicare BFCC-QIO.
- **Landscape Part 3** details the landscape assessment required under the CMS 13th Statement of Work for BFCC-QIOs. The report describes Livanta's planned activities to complete the landscape assessment. It also provides context for the findings reported in Landscape Part 4 and 5.
- **Landscape Part 4** will include regional summaries of Livanta's BFCC-QIO service areas. Part 4 includes other data, such as census results and insights about the older adult population. The regional summaries contain state-specific factors that impact local health care. These include geography, demography, or other local issues.
- Livanta will submit **Landscape Part 5** to CMS in Spring 2025. This report will highlight Livanta's findings from the landscape assessment.

Have a question about this report? E-mail Livanta at Communications@Livanta.com.

About Livanta

Livanta is the designated BFCC-QIO for Medicare case review in CMS Regions 2, 3, 5, 7, and 9 (see Figure 1, below) and Medicare's national claims review contractor. As a BFCC-QIO, Livanta protects Medicare beneficiaries' rights to quality care and supports Medicare patients when they have concerns about their health care. Livanta's role is to review appeals and complaints in a timely and accurate manner. Livanta also supports beneficiaries through patient advocacy with a focus on person-centered care.

The QIO Program is one of the largest programs tasked with improving health care for Medicare beneficiaries. It is an integral part of the National Quality Strategy for providing better care and better health at lower cost. As an agency of the U.S. Department of Health and Human Services (HHS), CMS administers the QIO Program. The QIO Program's mission is to improve the quality and cost of services delivered to Medicare beneficiaries.

One of the core functions of the QIO Program is to improve quality of care for Medicare beneficiaries. Another core function of the QIO Program is to protect the Medicare Trust Fund. These two functions work together to ensure Medicare beneficiaries get quality health care that is reasonable, necessary, and rendered in the most appropriate setting for optimal cost without waste or avoidable risk. The QIO Program also responds to patient complaints, concerns about the Emergency Medical Treatment and Active Labor Act (EMTALA), and other contract duties.

Figure 1: Livanta's Service Areas: State and Territory Listing by CMS Region

CMS Region	States and Territories
2	New Jersey, New York, Puerto Rico, and the U.S. Virgin Islands
3	Delaware, Maryland, Pennsylvania, Virginia, West Virginia, and Washington, D.C.
5	Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin
7	Iowa, Kansas, Missouri, and Nebraska
9	Arizona, California, Hawaii, Nevada, and the Pacific Territories of American Samoa, Guam, and the Northern Mariana Islands

Section 1: Hospital Admissions and Discharges

When the Unexpected Occurs

Chest pain. A broken hip. An invasive surgery. A severe infection. Difficulty breathing. For these and myriad other reasons, thousands of people make a trip to the hospital each day.

Patients can be admitted to a hospital for several reasons, such as for treatment of serious or life-threatening injuries or medical conditions. Sometimes less serious conditions require treatment or monitoring that only a hospital can provide. In many cases, adverse health outcomes or even death could result without emergency interventions or acute care provided by the hospital.

For many, admission to the hospital is a rare event. However, older adults are hospitalized more often than younger adults and require more support after leaving the hospital (Mattison, 2024). One study reported there are more than 13 million hospital stays annually for Americans aged 65 and older (Zhengyi & Owens, 2021). Most admissions (92 percent) were for medical conditions and surgeries. Other common reasons included injuries, mental health care needs, and substance use conditions.

Emergency Care

Many patients who seek emergency care have suffered an acute injury and are able to return home once assessed and treated in the emergency department (ED). Some people present to the ED with chronic conditions or other health concerns and respond quickly to simple treatments. Others need x-rays or other tests to rule out serious health problems. In most hospitals, the treatment time in a busy ED can range from a couple of hours to up to 24 hours.

For people living with one or more chronic health problems, the ED is a place where they can be assessed, treated, and monitored. For these patients and those with serious injuries, the ED is often the first stop in a lengthier healthcare journey. Typically, a patient who requires ongoing hospital care passes through the ED. Once they are stabilized, they are then transferred to one of the hospital's inpatient units.



Observation Services

There are times in an ED when a doctor might decide to keep the patient in the hospital but not as a hospital inpatient. This is known as observation. Doctors rely on observation services when they need time to assess the patient's medical needs and their response to emergency medical treatment.

Observation services can last from a few hours to up to several days. When Medicare patients are in observation for more than 24 hours, the hospital is required to give the patient a form called the Medicare Outpatient Observation Notice (MOON).



Medical care for those in observation can often be provided in the ED. However, sometimes, patients are transferred to one of the hospital's inpatient units while they continue to receive observation services. Observation gives the physician greater flexibility in monitoring the need to admit the patient.

Observation services also allow the medical team to diagnose and treat problems that may resolve with treatment rather than admit the patient for intensive medical management. Observation stays can help prevent unnecessary and costly hospital admissions.

Whether the patient is in observation care or formally admitted as a hospital inpatient, they should get the same quality of care.

In other words, there is no difference in tests or treatments that are ordered whether one is an inpatient or under observation.

About the MOON

The Medicare Outpatient Observation Notice (MOON) advises Medicare patients of their observation services. This is important because Medicare benefits are different for hospital care rendered under observation and benefits for inpatient care. In general, Medicare pays for inpatient hospital stays under Part A at 100 percent. Observation services and other outpatient care is usually billed under Medicare Part B. Part B coverage is usually 80 percent. Part B includes cost-sharing requirements such as copays and deductibles.

Observation services are billed as outpatient care (Part B), so an observation stay can impact a Medicare patient's out-of-pocket hospital costs. Patients who do not realize they are in observation may be faced with unexpected hospital bills. Receiving observation services also affects Medicare coverage for post-discharge care like skilled nursing services or therapy.

Inpatient Status

The Definition of Inpatient

Healthcare workers often use the term inpatient admission when referring to the status of a patient who has been formally admitted to the hospital for acute care needs and other medical services.

Inpatient status means the patient's health status requires an intense level of care that only a hospital can provide. Usually, inpatient status includes 24-hour monitoring and other services that ensure the patient's condition is improved or stabilized. An individual is considered an inpatient of a hospital if a physician or other qualified practitioner orders the admission in accordance with rules under the Code of Federal Regulations (CFR) (CMS, n.d.).

Hospitals have additional documentation and other requirements under the CFR. According to the CFR, the admission order must be given by a qualified and licensed practitioner. This practitioner must have admitting privileges at the hospital and must be

familiar with the patient's hospital course, medical plan of care, and current condition. The admission order must be given at or before the time of the actual admission.

The Hospital Stay

Hospitals can bill Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights.

The physician should base the decision on a range of complex medical factors including the patient's medical history. Other factors include the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record.



The length of stay for many hospital inpatients is three to five days. Some patients with complex health problems are in the hospital for weeks at a time. It is important to note that care received at the hospital is intended to stabilize the patient and prepare them for the next appropriate level of care.

The goal of an inpatient hospital stay is to provide the patient with the medical care needed to return home or to their usual place of residence.

According to the Medicare State Operations Manual, the discharge goal is that the patient will “be able to return to the setting in which they were living prior to admission” (CMS, 2024). Often, this setting is the patient’s home in the community. Some people who need more support permanently live in a nursing home or other congregate living facility. In the case of a hospitalized patient who was transferred from another hospital, the discharge goal should be to return to their usual place of residence.

Of course, not every patient is able to return straight home after a hospital stay. Many Medicare beneficiaries continue their healthcare journeys in skilled nursing facilities Medicare Part A covers skilled services in these settings according to Medicare policy and coverage rules.

To cover skilled care after the hospital discharge, Medicare requires the patient to have a qualifying hospital stay. A qualifying stay is one for which the patient was a hospital inpatient for a minimum of three days.

For many people, the stay in a nursing facility helps them regain strength and return to better health and mobility. For some people, however, even the most effective therapy and nursing care in a skilled nursing facility is not enough for them to regain their prior level of functioning. These individuals may require major life changes such as permanently moving into the nursing facility for life-long care. Others who need extra support or more immediate access to healthcare professionals may move into an assisted living or other congregate living facility.

Just as with a hospital discharge plan, a discharge plan for a patient in a skilled nursing facility should help them be able to return home or to their prior residence.

Looking for more information on the differences between Medicare Part A and Part B and explanations of coverage rules? The Medicare & You Handbook describes Medicare's coverage policies. Download the 2025 handbook at the following link.

<https://www.medicare.gov/publications/10050-medicare-and-you.pdf>.

The Hospital Discharge Process

Planning for Discharge

Discharge planning at most hospitals begins when the patient is admitted or soon after admission.

Hospitals must decide if the patient is at risk of adverse outcomes post-discharge. If the patient is at risk, the hospital must prepare a discharge plan to guide their ongoing care. Any patient, representative, or doctor may request a discharge plan, even if the hospital decided that one was not needed.

Once a patient has been identified as needing a discharge plan, or one has been requested, the hospital must identify the post-hospital services that the patient will likely need. They must also confirm the needed services are available in the community.

This evaluation must account for the patient's capacity for self-care. If the patient's usual residence is a nursing home or other congregate setting, the hospital must determine if the patient can be cared for upon returning to that setting.

While evaluating the patient for discharge, the hospital must decide if the patient will be able to provide their own self-care. If not, the hospital must identify the patient's family or friends who would be willing, able, and available to help with this care. In this case, the hospital must provide training for the family member or other caregiver.

If neither the patient nor the patient's family or informal caregiver can meet the needs for care, then the hospital must locate community-based services that would allow the patient to return to their home. If no community-based services are available to provide for the patient's needs in their home, the hospital must assess options for transfer to

another inpatient or residential healthcare facility. These options include other types of care settings, such as assisted living facilities, nursing homes, or other inpatient facilities.

The Role of Hospital Discharge Planners

Hospital discharge planners are members of the healthcare team who speak with the Medicare patient when a discharge plan is being written. Discharge planners may be registered nurses, social workers, case managers, or others who help ensure a safe and effective discharge.



A discharge planner's duty is to create an interdisciplinary plan to ensure the patient's medical needs are addressed once they leave the hospital. Among other qualifications, these professionals must be familiar with Medicare rules such as when to give the Important Message from Medicare to the patient. The Important Message from Medicare explains the patient's rights to appeal the hospital discharge. It also gives details for how to start such an appeal.

After leaving the hospital, many patients require durable medical equipment (DME), skilled nursing, therapy, or other post-acute care or services. Discharge planners must assist Medicare patients and families in selecting post-acute care and service providers. This selection process should focus on the patient's preferences and needs instead of the convenience of the hospital. Discharge planners should then help arrange these services.

Did you know? Medicare's Acute Hospital Care at Home program is a part of a comprehensive effort to increase hospital capacity and maximize resources. This

program, which is still under evaluation, allows for certain health care services to be provided outside of a traditional hospital setting and within a patient's home. Intended to create flexibility for hospitals, this program is an expansion of the Hospital Without Walls initiative that launched at the start of the COVID-19 pandemic in 2020.

Read more at <https://qualitynet.cms.gov/acute-hospital-care-at-home>.

Descriptions of discharge requirements in this report are based on Medicare's State Operations Manual (Publication 100-07).

The State Operations Manual has appendices for each setting of care. The appendices are linked below. Each file includes survey protocols, regulations, and interpretive guidelines for the various types of Medicare-certified healthcare organizations and providers.

Access these documents at the following link:

<https://www.cms.gov/files/document/som-appendix.pdf>

Section 2: Effective Discharge Plans

The Road to Recovery

Discharge planning is the process of transitioning a patient from one level of care to the next (Patel & Bechmann, 2024).

Many hospital patients are discharged from the hospital to their home in the community. Some of these patients require nursing and physical or occupational therapy once they return home. This helps ensure they continue to regain their health. Home health agencies provide these skilled services.

Other hospital patients transition to post-acute care settings such as hospices or skilled nursing facilities (SNFs). Patients who need more intense medical monitoring may be discharged to a long-term care hospital (LTCH). Those who need more intense physical therapy may be discharged to an inpatient rehabilitation facility (IRF).

Regardless of the patient's journey, the discharging hospital or care provider must develop a discharge plan that guides this transition process. Medicare-certified providers are expected to involve patients in their discharge process.

“You’re Going Home!”

A common belief among patients is that they will stay in the hospital until they feel well enough to go home. However, inpatient hospital care is only covered for as long as it is needed to stabilize the patient’s medical condition—not for as long as the patient is feeling unwell.

Many patients are not aware that their recovery may need to continue outside of the hospital. For example, it is common for laboratory tests to be ordered after the patient is discharged home. The patient does not need to stay in the hospital for blood work to be monitored closely by doctors and nurses.

Patients can often be treated at home or in other care settings when they need pain management, antibiotics for severe infections, or symptom control.

Therapy, including physical therapy or occupational therapy, can be provided in a patient’s home, or in other Medicare-certified settings, such as a skilled nursing facility or inpatient hospice center. Many patients receive wound care, ostomy care, or other skilled nursing and therapy services in the comfort of their own homes.



The Important Message from Medicare and Hospital Discharge Appeal Rights

Read more about these topics and more in Part 1 of the Landscape report series.

Download Part 1 and other reports using the link below.

<https://www.LivantaQIO.cms.gov/en/About/Publications>

Individualized Plans

An effective discharge plan is tailored to the patient's specific needs. The discharge planning process must take steps to prepare for a patient's healthcare needs after they leave the hospital. Discharge planning should also account for the patient's goals and preferences for post-acute healthcare providers.

To be effective, this process must identify the patient's current needs. It must also anticipate their needs upon moving to the next level of care. The discharge planning process is intended to reduce the risk for adverse outcomes and hospital readmissions. Care plans that use an unmodified template are not helpful in addressing an individual's personal living situation and their unique healthcare needs.

Discharge plans should list new medications or other changes in the patient's drug regimen, diet, and activity level. Discharge plans should also include reminders about follow-up appointments with primary care physicians or specialists, as well as written orders for bloodwork or other monitoring tests. When the patient will have outpatient therapy and other treatments, these special instructions should be included.

A discharge plan could consist of simple home-going instructions or many pages worth of detailed follow-up information, patient instructions, and educational materials. Patients with multiple health problems are likely to have lengthy or complex discharge plans.

For example, when leaving the hospital, some patients have numerous follow-up appointments, changes in their medications, and new diet orders or dietary guidelines to follow. Many patients leave the hospital with therapy orders, orders for durable medical equipment (DME), and activity restrictions. Others have worksheets and reminders to conduct self-monitoring of weight, blood pressure, or other vital signs. For some patients, home modifications are necessary for them to return home safely. This may include wheelchair ramps, grab bars, or other structural or plumbing changes to ensure their mobility, safety, and health needs are met.

Creating A Framework

Effective discharge plans provide the framework for patients to take the next steps in their recovery by helping to summarize and reinforce their instructions for ongoing treatment. Note that if the patient's health condition changes prior to discharge, it may lead to the need to change or pause the discharge plan.

Written discharge instructions must be legible, written in plain language, and be age appropriate and culturally sensitive. Discharge plans often include the elements described below. Because patients' needs are unique, this is not an exhaustive list.

- A brief description of the patient's hospital stay and medical condition.
- A list of medications, doses, and instructions. This list should include changes from the patient's previous medication regimen. The discharging doctor often sends new medication orders to the patient's pharmacy of choice before they leave the hospital. Sometimes, the patient is given written prescriptions instead that they must get filled on their own.
- A list of follow-up appointments with primary care doctors, specialists, clinics, or other providers. Patients who have been treated for multiple health problems are likely to have follow-up appointments with each treating specialist so their health and response to treatment can be monitored. Many primary care physicians make it a priority to schedule follow-up appointments with their hospitalized patients within seven days of the hospital discharge. Sometimes these appointments are scheduled at the time of the hospital discharge. However, sometimes patients are responsible for making their own follow-up appointments.
- Details regarding any durable medical equipment (DME) that the patient will need. DME is certain medical equipment that is ordered for the patient's extended use. Some examples of DME include wheelchairs, bedside commodes, and oxygen equipment. Many times, DME is ordered in advance of the discharge to prevent adverse health outcomes. For example, when a patient needs home oxygen, the equipment must be delivered prior to their arrival at home. Hospital discharge planners must ensure any needed DME will be available and help coordinate delivery to the patient's home.

Discharge plans should also include these additional items when appropriate.

- Orders and paperwork to complete laboratory work or other tests or procedures. Depending on the hospital system and what has been ordered, these orders are often entered into the electronic health record (EHR). Sometimes the procedures are even scheduled for the patient. In these cases, the patient is given written reminders of the tests and the dates and times of any scheduled procedures. Other times, the patient is responsible for scheduling and completing these types of tests on their own.
- Instructions for self-monitoring. For example, many patients with congestive heart failure are instructed to weigh themselves daily and report weight gain to their doctor or nurse. Others must keep a log of home blood pressure readings or blood sugar levels.
- Other factors that are critical to the patient's recovery. For example, if a home health agency will be seeing the patient in their home, details about the agency are provided to the patient. These details might include contact information for the agency and the day and time to expect the first nurse to visit.
- Referrals to pertinent community resources that may be able to assist with financial, transportation, meal preparation, or other post-discharge needs.

Medicare's Care Compare Website

Medicare's innovative Care Compare helps locate a range of healthcare providers. The comparison tool displays Medicare star ratings for each hospital, nursing home, home health agency, and other Medicare-certified healthcare providers. The tool also includes maps, filters, and simple navigation that makes it easy to find important information when comparing providers.

Click the link below to learn more and use this powerful online tool.

<https://www.medicare.gov/care-compare/>

Patient and Family Caregiver Education

The patient's medical team must ensure the patient's post-hospital care is safe and effective. This process should include training for the patient to ensure they can properly provide self-care once they return home. When the patient's family members or other support person(s) will be providing care, they should be included in the training.

Nurses and discharge planners should provide training about the patient's disease, medications, and treatments. Other topics include diet and nutrition, symptoms to watch, and details for when and how to seek help. Checklists and other forms can be helpful teaching aids in patient and caregiver education.



Unfortunately, when discharge plans are not followed, negative health outcomes are more likely to result. Thus, patient and caregiver training must be effective. Teaching methods must be based on recognized methodologies, such as the teach-back method.

Many types of tools and techniques can help improve patient outcomes after they return home. For example, the teach-back method is a simple tool that helps patients and caregivers repeat instructions using their own words. The teach-back method helps reinforce key points and identify if more training is needed. Other approaches include having the person repeat back verbal instructions to ensure accuracy and the use hands-on training for skill building.

Other Discharge Contexts

This report describes typical discharge processes of Medicare patients who are discharged from the hospital to home. However, every day, thousands of hospitalized Medicare patients are discharged to skilled nursing facilities (SNFs), and countless others are discharged from SNFs to home or their usual place of residence. Even home health agencies can discharge a patient from their services, although the patient does not physically move from one location to another.

It is impossible to account for every possible scenario that a Medicare patient may face during their healthcare journey. However, in each of these scenarios, various Medicare regulations apply. For example:

- When a Medicare patient is to be discharged to a SNF, the hospital discharge planner must provide a list of facilities and certain information about the facilities such as quality measure data. These details help the patient to make an informed decision about their post-acute care. In a similar way, when a Medicare patient is leaving a SNF and will resume skilled care at home with a home health agency, the SNF's discharge planner or social worker must assist the patient with selecting a home health agency.
- When a SNF, home health agency, or other post-acute care provider is terminating a patient's covered services under Medicare Part A, they must give the Notice of Medicare Non-Coverage (NOMNC). This form is similar to the Important Message from Medicare that patients receive in the hospital. The NOMNC gives important information about the patient's rights to appeal the termination of services. Medicare patients have the right to appeal the termination of their Medicare-covered services with the BFCC-QIO. Read more about post-acute appeal rights in Appendix B of this document.

Regardless of the patient's journey, Medicare-certified providers are expected to involve patients in their discharge process. It is critical that healthcare providers educate patients and families to ensure they understand what is happening with their care and their health.

Section 3: Transitions of Care

The Complex World of Health Care

Call to mind any Norman Rockwell painting, and it is easy to imagine a country doctor making a house call with a black leather satchel in tow. With limited technology and simple care delivery structures, one doctor often single-handedly diagnosed and treated a community of patients. Contrast that simple image with today's dizzying networks of healthcare systems and providers.

Today, a hospital patient is usually under the care of an attending physician such as a hospitalist or other practitioner. If the patient has multiple health problems, many specialists may also be involved. The medical team includes nurses, therapists, and other ancillary support staff. Depending on the patient's needs, other personnel such as dietitians, pharmacists, and technicians may be involved. In this way, multiple disciplines come together to provide a tremendous amount of care to a patient in a relatively short amount of time.

The need for this type of comprehensive inpatient care poses a challenge in coordinating the patient's post-acute care.

Care Transitions

From Here to There

Common descriptions of care transitions include the notion of a patient moving from one setting of care to another.

A simple image that depicts this concept is the patient who goes straight home after an ED visit—for some, the transition of care is little more than the car ride home and a follow-up appointment with their primary care provider. For other patients, the transition may be from the hospital to a skilled nursing facility (SNF) or long-term care hospital (LTCH). Such transitions may require ambulance services or special equipment.



Transitions can be thought of as any handoff between patient care teams, internal departments, or settings of care. Thus, transitions occur any time a patient moves *within* or *between* settings of care. For example:

- An ED patient who is admitted to the hospital experiences a care transition when being transferred to the hospital's inpatient unit.
- A hospital inpatient experiences a transition from the medical floor to the radiology department for testing.
- A home health patient receiving skilled physical therapy may be discharged from the agency and resume their therapy at a comprehensive outpatient rehabilitation facility (CORF).
- An individual without a hospital stay but who is under the care of multiple medical specialists could have countless transitions as they move between primary care, specialty care, and various outpatient services.

Transitions Include Communication Handoffs

Behind the scenes, healthcare professionals must have the tools, information systems, and support to ensure the patient's needs are being met. Without effective processes, mistakes can occur, safety checks can be lacking, and delays or other adverse outcomes can occur.

For example, think of a nurse who conducts an intake assessment when a patient is admitted to the hospital. Suppose the patient says he has an allergy to contrast dye. If the nurse does not document the allergy and communicated properly, the patient could suffer severe harm when arriving in the radiology department for a computed tomography (CT) scan.

This is one simple example of an adverse outcome that could occur during a care transition. When care transitions include a transfer between settings or a change in level of care, there are countless opportunities for care to be unsafe or ineffective. For this reason, it is crucial that the healthcare community makes care transitions a high priority for ongoing improvement.

Care Transitions

A transition of care is more than a patient simply moving from one point to another. Although hospital discharges represent some of the most common care transitions, care transitions can refer to any number of points in the patient's journey. As the patient moves within or throughout the continuum of care, numerous communication points and care plans must be coordinated. Every patient handoff requires awareness, attention to critical patient details, and effective communication.

Pivotal Moments in the Patient Journey

Whether the mode of transport is a private car, an ambulance, or a hospital gurney, all care transitions are crucial moments in the patient's healthcare journey.

These points in time are crucial for safe patient care. For at-risk hospital patients, a trip to the operating room or the therapy gym are also times that harm may occur. The same holds true for patients who are ready to leave the hospital and transfer to another location. Vital details about a person's health, medications, allergies, mobility status, treatment plans, future appointments, and other details must be communicated clearly and efficiently.

For nearly all patients, discharge from a hospital and transportation home or to the next location of care is only the starting point for the care and coordination of services that are to come.

Some of the most crucial transitions of care are those that occur between healthcare settings.

Care transitions that occur between two different healthcare providers often involve different levels of care. Two common levels of care are acute care and post-acute care. Acute care refers to hospitals, long-term care hospitals (LTCHs), and inpatient rehabilitation facilities (IRFs), while post-acute care providers typically include skilled

nursing facilities (SNFs), home health agencies, hospices, and comprehensive outpatient rehabilitation facilities (CORFs).

Many large hospital systems also operate SNFs, home health agencies, and other post-acute service providers. For some patients, transitioning to other providers within the same health system helps to ensure basic continuity of care. For example, if the hospital and home health agency are part of the same hospital system, it is common for them to use the same electronic health record (EHR). When providers use different EHR systems, information sharing between organizations is often more complex and can lead to communication gaps, delays, or other problems.

Care Coordination

A Series of Steps

Care coordination is a series of steps taken by one or more healthcare providers to ensure the appropriate delivery of healthcare services. When the only care provider is a single doctor, this task is simple. However, when numerous referrals, tests, procedures, and other follow-up care are ordered, it is all too easy for care to become fragmented.

Care becomes fragmented when communication gaps occur, necessary tests are duplicated or missed, or when other types of errors happen. Fragmented care can result in patient harm and can decrease patient satisfaction.

The activities of care coordination can be illustrated with the example of a primary care practitioner (PCP) referring a patient to a specialist. Typically, the PCP's office



staff coordinates the exchange of patient information with the specialist's office. This information often includes the patient's name, date of birth, insurance information, health conditions, lab results, and other pertinent details. During this exchange of information, the appointment is scheduled for the patient.

In addition to ensuring the correct care and follow-up health services for a patient, proper care coordination helps to reduce waste. For example, when a patient has had laboratory testing, it is common for the results of the blood tests to be available to some or all of the patient's doctors, not just the ordering physician. In this way, duplicate testing can be prevented.

This type of information sharing between providers requires interoperability of various EHRs. Interoperability refers to the ability of different EHRs to connect and relay patient-specific information. In today's increasingly complex world of health care and health networks, interoperability of information systems is paramount for healthcare organizations.

The Patient Experience

When care transitions involve a discharge from a hospital to another level of care, it can be a very confusing time for patients and their families. It is also confusing when multiple organizations are involved and arranging the patient's care. However, it can be less confusing if patients receive clear information and instructions.

As noted in Section 1 of this report, an effective discharge plan is one in which the patient or their caregiver has participated, understands the plan and the information provided, and has identified any concerns they have about potential post-discharge challenges. For many individuals who live at home, the involvement of a family member or other caregiver can be a needed support. Family caregivers are discussed more in Section 4 on page 36.

When patients have experienced health setbacks or other challenges, there is an added layer of complexity as they often have changes to their medication regimen and must adapt to new diagnoses or lifestyle changes to regain their health or to stay healthy. For

these individuals, ensuring they get the needed post-acute care is often a moving target.

Potential Pitfalls

All transitions of care are critical to a patient's journey to recovery. Poorly coordinated care transitions can lead to patient harm, readmission, and other negative health outcomes.

Care coordination is generally the responsibility of healthcare providers. However, patients must be actively involved in their own health and complete any orders for follow-up care. Being aware of potential pitfalls can help patients and providers alike. From knowing how health literacy and health-related social needs impact a person's health to understanding the importance of medication adherence, patients and providers can work together to achieve better outcomes. The next section highlights key areas that are often pitfalls for patients. These topics include medications, health-related social needs, and delays in care.



Medication Reconciliation and Medication Adherence

According to an Institute of Medicine (IOM) study, medication mistakes are the most common type of patient safety error (IOM, 2007). The study reported that 40 percent of medication errors are a result of poor care coordination, and 20 percent of those errors result in patient harm.

According to a study published in *BMJ Open Quality*, medication errors led to up to 66 percent of all adverse effects patients had after their discharge (Kreckman, et al., 2018). Medication errors claim the lives of up to 9,000 people each year in the U.S. (Tariq, Vashisht, Sinha, & Scherbak, 2024). Complications from adverse drug events lead to countless hospital readmissions and cost billions of dollars each year. Medication reconciliation is a vital step during transitions of care and can help reduce the chance of medication errors. This process is performed by physicians, pharmacists, nurse practitioners, or physician assistants.

Medication reconciliation is the process of ensuring a patient's medication list is accurate and that all medication-related care items have been addressed. This process also helps identify drug interactions and other areas of concern.

The step of comparing current medication orders to prior medication orders helps verify dosages to prevent over- or under-prescribing. It also helps ensure that discontinued medications are no longer listed and that new medications are included. Important considerations such as drug allergies and drug interactions should also be addressed.

Medication Reconciliation

Medication reconciliation is a multi-step process of reviewing a patient's medications, including dosage and frequency, and confirming intended changes from the patient's previous regimen. An important part of the process is to resolve any discrepancies that are found. During this review, the practitioner can identify dosage changes and possible drug-to-drug interactions or prescriptions that may not be appropriate given the patient's medical history. Also, some medications require a specific therapeutic level that is monitored with lab testing and these orders should be verified.

The importance of effective medication reconciliation cannot be overstated, especially for patients with multiple conditions who take many medications. Medication reconciliation is not complete without including the patient. The last step is ensuring that patients and their caregivers understand and can follow the medication plan. Medication adherence, a term that refers to following the prescribed medication plan, is challenging for many patients.

A 2012 study reported several alarming impacts related to medication orders (Neiman et al., 2017):

- 20 to 30 percent of new prescriptions are never filled at the pharmacy.
- 50 percent of medications that are filled are not taken as they were ordered.
- The cost of medication nonadherence to the U.S. healthcare system ranges from \$100 billion to \$300 billion per year.



Medication nonadherence, or not following the prescribed medication plan, can be caused by a range of factors. Some of these include high out-of-pocket costs, low health literacy, forgetfulness, and improper medication reconciliation.

Medication nonadherence is estimated to result in 125,000 avoidable deaths each year (Bosworth et al., 2014). Providers should review the reconciled medication list with patients and caregivers to ensure they fully understand the prescribed medications. Patients and their caregivers need to know the names of the medications, when and how to take them, and how much to take. Understanding and managing medicines are fundamental for ensuring patient safety, effective treatments, and overall well-being.

Health-Related Social Needs

Beyond the challenges of filling and taking prescribed medications, a patient may have other reasons for not following the discharge plan. For example, patients who have congestive heart failure are often ordered to weigh themselves daily at home to detect fluid overload. If they do not have a bathroom scale or the means to purchase one, they may be at risk of complications and readmission.

Health-related social needs, or HRSNs, are non-medical personal factors that influence a person's health status. Some patients may have a harder time overcoming such barriers. For example, patients who do not have financial resources or reliable transportation often face challenges with their health. Those without nearby family members or other sources of social support may have similar challenges.

HRSNs often include an individual patient's economic strain, which may lead to lack of food, poor housing, unsatisfactory education, and inadequate access to health care. Unmet HRSNs can lead to worsening health outcomes for certain health conditions, such as diabetes, heart disease, depression, or cancer.

Categories of HRSNs include housing instability, food insecurity, transportation problems, utility help needs, and interpersonal safety. CMS recognizes additional domains such as financial strain, employment, and family and community support. Other domains include education, physical activity, substance use and mental health, and disabilities (CMS, n.d.).

Delays

Medical care following a hospital discharge or other care transition does not happen all at once. Unfortunately, delays in care or treatment plans can result in adverse outcomes. There are many kinds of delays, including access delays and communication delays. Waiting for return phone calls or other types of communication delays is a common challenge for patients and providers alike.

Timely access to care is critical to restore and maintain health. For example, patients who cannot get appointments for diagnostic testing for several weeks or months may experience worsened health outcomes. This is especially true when the test reveals a serious diagnosis and the treatment plan depends on those test results.

Another example of an adverse outcome is when a pharmacy delay leads to the patient being unable to take prescribed medications as ordered. Delays at the pharmacy can be caused by a wide range of factors, such as unclear physician orders or unavailability of the medication. Another common issue is the need to obtain prior authorization from the patient's insurance, which can be a slow process.

Computerized Provider Order Entry (CPOE)

Today's technology has increased the speed of everyday communications. For instance, with computerized provider order entry (CPOE), providers can enter and send treatment instructions and prescriptions via a computer application. Rather than sending paper hard copies or giving verbal or faxed orders, doctors and other prescribers can now send medication, laboratory, and radiology orders at the touch of a button. Patient portals, which are consumer-friendly applications that connect to the patient's medical record, allow many patients to send electronic messages to their care team.

Health Literacy

In many cases, patients and caregivers do not fully understand the information presented to them in their hospital discharge plans.

Discharge instructions are given to patients and their caregivers prior to the patient leaving the hospital. These plans contain critical information and instructions for the patient and caregiver to follow when returning home or transferring to another level of care.

Not understanding discharge instructions—and therefore not following them—is a clear example of how having low health literacy can negatively affect a



patient's health outcomes. One study showed that patients with low health literacy were less likely to use educational information and engagement tools such as a patient portal (Bakerjian, 2023).

Providers must allow for the use of interpreters if they do not speak the patient's native language. Having translated written materials, especially the discharge plan, is critical to ensuring patients and caregivers fully understand their medical information.

Read more about health-related social needs, health literacy, language needs, and other critical topics that impact patients' healthcare journeys in Landscape Part 1, available at <https://www.LivantaQIO.cms.gov/en/About/Publications>.

Accountable Care and Accountable Health

Traditionally, the primary care physician is the central point of a patient's care, as the practitioner who knows the patient's full medical history and generally helps with recovery from acute illness or injury and manages the overall care. Ideally, a patient's primary care provider is connected to the hospital and other care settings in the local community. Models such as the Accountable Care Organization (ACO) and Accountable Health Community (AHC) exist to ensure that there is coordination between all levels of care.

An ACO is a network of physicians, hospitals, and other medical providers and/or healthcare organizations that voluntarily collaborate in the care of their common patients, with the goal of advancing the triple aim of better health, better care, and lower cost. These healthcare providers are usually located within a given geographic area and work together to ensure that the delivery of medical services to patients is coordinated and efficient.

Like ACOs, AHCs play a role in coordination of services across a geographic community. However, whereas ACOs focus on coordination of healthcare services for Medicare beneficiaries within a community, AHCs focus on coordinating community services that support the overall health of beneficiaries. Originally created by CMS in 2017 as a five-year pilot program, the AHC program's website contains several resources and reports and other useful information.

View the AHC website here: <https://innovation.cms.gov/innovation-models/ahcm>

Section 4: Hospital Readmissions

A Detour on the Road to Wellness

A person can be admitted to the hospital for many reasons. If all goes well, the road to recovery begins and the individual is discharged. Unfortunately, many patients are readmitted to the hospital because of a worsening in their health.

One of the most significant issues facing the healthcare system, patients, and families is the threat of needing to return to the hospital for additional medical care. Although there are many ways to measure hospital readmissions, one common metric is an unplanned repeat admission to the hospital within 30 days of the patient's prior discharge.

Unplanned readmission is a serious issue that costs the healthcare system billions of dollars annually. These readmissions can also be dangerous for patients, exposing them to healthcare-acquired conditions and other risks associated with inpatient care. Hospitalizations and readmissions can be devastating for patients and caregivers in other ways, such as potential changes in social or family support, loss of income, or other incurred costs.

The Prevalence and Cost of Readmissions

In a 2009 study, nearly 20 percent of all hospitalizations for Medicare patients resulted in a readmission within 30 days (Jencks, Williams, & Coleman, 2009). These estimates placed the annual cost of readmissions in 2004 at \$17 billion. Newer estimates suggest even higher costs. Tens of thousands of lives are lost each year due to healthcare-acquired infections and other healthcare-acquired conditions.

Although the economic factor alone is cause for concern, each readmission also represents stress and potential trauma for the patient and their caregivers. In addition to the personal and family stress leading up to and occurring at the time of readmission, each visit to the hospital increases the risk of the patient experiencing a healthcare-acquired condition, such as an infection, pressure ulcer, fall, or other trauma. The root cause of these costly readmissions can often be traced to transitions of care issues or lack of patient engagement.



Preventing Avoidable Readmissions

A study published in 2016 in the *Patient Experience Journal* found that when patients and caregivers felt that they were not involved in care decisions, a readmission was more likely (Kemp, Hude, & Santana, 2017). The same was true for patients who said they did not receive written information about which signs and symptoms to monitor after returning home.

According to *Families Caring for an Aging America*, integrating informal caregivers into the discharge planning process can significantly reduce hospital readmissions over three- and six-month periods (Schulz & Eden, 2016). The report also noted that including these caregivers can also reduce costs of post-discharge care.

Another study, published in *The American Journal of Managed Care* in 2015, showed that by implementing an approach to discharge planning based in the concept of the patient-centered medical home (PCMH), readmissions could be significantly reduced among patients aged 60 and over (Stranges & Marshall, 2015). The intervention, known as the Transitional Care Program (TCP), included a clinical pharmacist, social worker, and the primary care provider.

As these and other critical insights began emerging in the mid-2010s, healthcare organizations across the country began to implement person-centered care models for discharge planning. The goal of these programs is to assist patients and caregivers with care after a hospital stay, with the goal of preventing a subsequent readmission to the hospital. If a patient and caregiver understand the discharge plan and are invested in following it through, a readmission can often be prevented.

Improvement Programs

In response to poorer health outcomes associated with readmissions, CMS has been at the forefront of this significant issue, developing effective policy solutions and spurring quality innovation. In 2012, CMS formally instituted the Medicare Hospital Readmissions Reduction Program. As the foundation of this program, CMS analyzed readmission data from hospitals across the U.S. that participated in Medicare.

Hospitals with readmission rates that were higher than average were identified through data analysis, and financial penalties were levied against hospitals whose readmission

rates continued to be higher than average. For nearly a decade, this program has successfully used financial incentives to encourage hospitals to reduce their readmission rates. In addition to the CMS penalties, over the last several years, many innovative patient-centered approaches have been instituted by providers and practitioners at the state and local levels.

Part of the strategy for improving health outcomes and avoiding unplanned readmissions is to provide holistic patient-centered care that identifies the person and their unique needs and risk factors. Many of the root causes of poor transitions of care relate to a lack of coordination among the care team.

As an example of patient-centered care strategies, the Agency for Healthcare Research and Quality (AHRQ) published the IDEAL Discharge Planning Implementation Handbook for healthcare professionals. This toolkit was designed to help patients and their caregivers transition from hospital to home care. This comprehensive approach—which stands for include, discuss, educate, assess, and listen—engages patients and caregivers throughout the discharge planning process. Read more about the IDEAL toolkit in Appendix C.

Steps in AHRQ's IDEAL Discharge Planning

- **I – Include** patients and caregivers throughout the discharge planning process.
- **D – Discuss** potential issues with patients and caregivers: review medications, highlight warning signs and problems, explain test results, make follow-up appointments
- **E – Educate** patients and caregivers using plain language.
- **A – Assess** how well doctors and nurses communicate the patient's diagnosis, condition, and next steps to family members and caregivers.
- **L – Listen** to patients and their family members' goals, preferences, observations, and concerns.

CMS's Guide to Reducing Disparities in Readmissions

According to CMS, hospital strategies for preventing avoidable readmissions include a focus on reducing language barriers and improving health literacy. Understanding commonalities of readmitted patients, such as age, race, number of medications they take, or their overall health, would allow hospitals to improve allocation of resources. Keeping patients healthy after their discharge from the hospital can also include a focus on home services, technology, mental health support, caregiver assistance, and community partnerships.

CMS's Guide to Reducing Disparities in Readmissions (see link in Appendix B) recommends a multidisciplinary team approach including doctors, nurses, social workers, interpreters, and allied health workers. The report highlights other ways to help reduce avoidable readmission rates. Some of these methods include:

- **Collect critical data and identify root causes:** Collect data such as the beneficiaries' race and ethnicity, language, education, and social determinants of health. Analyze demographic and risk data to identify the root causes of readmissions and targeted interventions, such as provider training and language services.
 - **Systematically address social determinants:** Patient navigators, social workers, and community health workers, can help ensure culturally and linguistically appropriate patient information and resources.
 - **Provide culturally competent communication:** Strategies include the use of interpreters, plain language discharge instructions in multiple languages, and staff training on cultural competence. Particular attention should be given to medication reconciliation and discharge instructions, especially for minority populations.
 - **Foster external partnerships to promote continuity of care:** Hospitals should establish partnerships with community providers and leverage community programs that address social determinants, health equity, and other priorities.
-

Section 5: Family Caregivers

Families in Crisis

All too often, an older adult experiences a major decline, either prior to or in conjunction with their hospital stay. Individuals who once were healthy and living independently can quickly become ravaged by disease or a worsening health status. In many cases, people require more support to continue living in their own homes.

When a person's independence starts to slip, it can take a toll on the individual and their family members. Suddenly, the health crisis that was treated at the hospital has led to major household changes and new needs to address. For example, if an older adult who was once vibrant and spry suffers a major injury, questions will arise as to how they will complete daily tasks such as bathing or meal preparation. Other questions may loom regarding transportation to follow-up doctor appointments or whether they can even climb the steps to their front door.

When a family member or other informal caregiver is involved in the patient's usual care at home, the discharge process should account for this person's availability and ability to provide support.

Who Are Family Caregivers?

With more and more Americans living longer lives, many family members, friends, and neighbors inevitably find themselves falling into the role of caregiver. In the work of the RAISE Family Caregiving Advisory Council, the term “family caregiver” is deliberately used as a broad term.

The council’s definition of family caregiver accounts for spouses, other relatives, friends, and other “chosen” family. Family caregivers, as defined by the RAISE Family Caregiving Advisory Council, includes:

“All unpaid individuals of all ages who are caring for individuals with disabilities, chronic or other health conditions, and/or functional limitations. This term includes family members, partners, friends, kinship and grandfamily caregivers, and the untold millions of youth across the nation who care for family members, regardless of the type of assistance needed. It includes part time caregivers and full-time caregivers.” (RAISE Family Caregiving Advisory Council, 2021)

The recovery, continued well-being, or even the very survival of a loved one is often dependent on an informal caregiver.

The act of caregiving can be as simple as giving an aging relative or neighbor a ride to their physical therapy session or doctor appointment. Caregiving can also be much more involved, such as providing hands-on assistance with activities of daily living such as bathing or grooming for a spouse or parent who develops a life-altering medical condition.



Family caregivers are usually unpaid individuals who step in to help care for someone—often a family member or friend—who needs temporary or permanent assistance. For more information on the RAISE Family Caregiving Advisory Council, see <https://acl.gov/programs/support-caregivers/raise-family-caregiving-advisory-council>.

Family Caregivers and Transitions of Care

Older adults and others who have multiple health conditions are especially prone to adverse outcomes during transitions of care. The risk for delays or other care coordination problems magnifies the challenges of the discharge itself, potentially leading to more difficult transitions of care and additional stress on the caregiver.

Situations in which a Medicare beneficiary's health or functional ability has suddenly changed can take a toll on the individual as they grapple with diminished health and their lost independence. The person's family or community support system may also be impacted as they strive to understand the extent of the changes and what is needed going forward. They may have to adjust their own personal or work schedules or make other accommodations.

Receiving an unexpected discharge or service termination notice can often throw a patient and their family into panic. In many cases, when a patient is being discharged home, the family or caregivers may not have expected the patient to return home so soon. Modifications such as wheelchair ramps or bathtub grab bars may need to be made to the patient's home to ensure a safe environment.

In addition to needing more time to prepare for the patient's return home, sometimes patients and caregivers may not fully understand the details in the discharge plan. Discharge plans sometimes use complex healthcare jargon that can be difficult for patients and caregivers to decipher. This is problematic because when patients and caregivers do not understand discharge instructions, they are less likely to follow them, which can negatively affect a patient's health outcomes and cause preventable hospital readmissions.

Trips to the hospital can be a burden to family caregivers or others who help manage a patient's medical problems. When a patient is discharged home, caregivers or family

members must often alter their schedules or take time off work to assist with the patient's transition to their daily routines and activities. In the event that the patient's medical condition deteriorates, and a subsequent readmission occurs, the cycle begins again, causing repeated disruption to the patient, family, and other caregivers.

Training for Family Caregivers

Help for family caregivers exists in many forms, from locally organized support groups, internet sites, and online forums to state and federal agencies and non-profit organizations. Yet, this wide array of support and resources can itself be a source of confusion for caregivers, as they must sift through volumes of information to find the help they need.

Furthermore, the responsibility for finding these resources often falls to the already-burdened caregiver, who may have the will, but not the skill or the time to do so. Caregiving can be an exhausting, around-the-clock effort with few opportunities to step away and seek out needed help. Although training exists for formal caregivers like nurses or home care aides, very little training is available for family caregivers. As an example, consider a spouse caring for her husband who is recovering from a heart attack. This new caregiver must learn quickly to navigate the reality of providing for her husband's daily care needs while also helping him navigate his follow-up medical care.

This description may sound simple, but a discharge plan for this scenario may include dietary restrictions such as a low-sodium diet or other heart-healthy diet modifications, new medications, instructions for monitoring blood pressure readings and other vital signs, activity limitations, follow-up testing, and other medical appointments. If the caregiver is a spouse who is also an older adult, he or she may also have to manage their own health conditions at the same time.

The Perils of Caregiver Burnout

For many caregivers, the personal rewards of caring for loved ones are often overshadowed by the stress that accompanies caregiving. When caregivers have difficulty navigating the healthcare system or understanding health information, it can be frustrating.

Not all family caregivers volunteer for their role, and for some, personal rewards are absent altogether. Regardless of the circumstances, caregiver burnout can happen quickly and can affect the health of patient and caregiver alike.

According to studies noted by the Family Caregiver Alliance, caregivers experience significant rates of depression and other mental health disorders. For example, up to 70 percent of caregivers report symptoms of depression (Family Caregiver Alliance, 2006).

In addition to the mental or emotional challenges of suddenly taking on the role of caregiver, these studies have shown that caregivers report higher levels of substance abuse and physical manifestations of stress such as acid reflux and headaches.

Increased stress hormones and lower levels of antibodies in caregivers can lead to higher incidence of severe disease or infection. Caregivers who are older adults themselves seem to pay the highest price. Studies have shown that they have a 63 percent higher 4-year mortality rate than their non-caregiving peers (Schulz & Eden, 2016).



The Right to Appeal, Complain, and Get Help

Medicare beneficiaries with Original Medicare and Medicare Advantage plan members can contact Livanta for help with their healthcare concerns. This can be especially helpful when there is disagreement with the discharging facility or an insufficient discharge plan. As a Beneficiary and Family Centered Care – Quality Improvement Organization (BFCC-QIO), Livanta advocates for patients and their families or other caregivers when they have issues with their care and reviews medical records to ensure appropriate care was delivered.

Read more about the services of the Beneficiary and Family Centered Care – Quality Improvement Organization (BFCC-QIO) in Appendix B.

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Appendix A: Acronyms

AHRQ	Agency for Healthcare Research and Quality
BFCC-QIO	Beneficiary and Family Centered Care – Quality Improvement Organization
CMS	Centers for Medicare & Medicaid Services
CFR	Code of Federal Regulations
CORF	Comprehensive outpatient rehabilitation facilities
CPOE	Computerized provider order entry
DME	Durable medical equipment
ED	Emergency department
EHR	Electronic health record (also called electronic medical records, or EMRs)
EMTALA	Emergency Medical Treatment and Active Labor Act
HRSN	Health-related social needs
IM	Important Message from Medicare
LTCH	Long-term care hospital
MOON	Medicare Outpatient Observation Notice
NOMNC	Notice of Medicare Non-Coverage
PCP	Primary care practitioner (or provider)
SNF	Skilled nursing facility
SOW	Statement of Work

Appendix B: BFCC-QIO Services

Hospital Discharge Appeals

When a hospital admits and discharges a Medicare beneficiary, it must give the beneficiary a Medicare notice called the Important Message from Medicare (IM). This form explains how to file an appeal with the Beneficiary and Family Centered Care – Quality Improvement Organization (BFCC-QIO) QIO. Medicare patients can appeal if they believe their hospital discharge is happening too soon. They may do this if they do not think they are well enough to leave, or the discharge plan is inadequate or unsafe. This BFCC-QIO service includes a medical record review.

If the beneficiary wishes to begin an appeal, they call Livanta's Medicare Helpline. They can also start the appeal process on Livanta's website. When the appeal is made, Livanta requests the medical record from the facility. Right away, one of Livanta's independent physicians reviews the medical record to determine whether a continued stay or services is appropriate and necessary. Anyone can call Livanta's helpline to begin an appeal.

Post-Acute Appeals

Medicare patients can also appeal if they believe covered services are ending too soon, such as when receiving skilled care in a nursing home. Other care settings include home health, hospice, and outpatient rehabilitation facilities. When deciding to terminate covered services, the provider issues a Notice of Medicare Non-Coverage (NOMNC) form to the patient. Like the Important Message from Medicare, the NOMNC form includes contact information for the respective BFCC-QIO. Beneficiaries or their family members can call Livanta's Medicare Helpline to begin the appeal for the termination of these services. The review process is similar to hospital discharge appeals.

Quality of Care Complaints

Beneficiaries have the right to file a formal, written quality-of-care complaint about the health care they received. BFCC-QIOs like Livanta are charged with reviewing a patient's medical record to ensure the beneficiary received quality care. To file a complaint, a beneficiary or family member calls Livanta's Medicare Helpline. Livanta's review coordinator clarifies the details of the complaint and obtains the patient's medical

record from the provider. A Livanta physician reviewer determines if the documented care adhered to current standards. Either the beneficiary or the healthcare provider may request a reconsideration.

Immediate Advocacy

Instead of filing a formal, written complaint, Medicare patients can get help to resolve a problem they are having with their care. The advocacy service does not include a medical record review. Livanta's skilled advocates work by phone with Medicare patients and providers to resolve issues promptly. To begin an advocacy case, the beneficiary or family member calls Livanta's Medicare helpline and agrees to the process. Livanta then contacts the health care or service provider and intervenes on behalf of the patient to help resolve the concern. Livanta's advocates can resolve most problems within a few days. If the provider declines to participate in the discussion, the beneficiary may file a formal, written quality of care complaint.

Other Types of Case Review

BFCC-QIOs like Livanta often receive referrals from the Centers for Medicare & Medicaid Services (CMS) or other entities. While many of these referrals are based on complaints of substandard care, some are based on violations of the Emergency Medical Treatment & Active Labor Act (EMTALA). BFCC-QIOs also review cases in which beneficiaries appeal Hospital-Issued Notices of Noncoverage (HINN). Recently, a federal court found that certain Medicare patients who were admitted as hospital inpatients have the right to appeal a change in their status to outpatient status. BFCC-QIOs are expecting these appeals to begin in January 2025.

Learn More

Learn more about Livanta's BFCC-QIO services in Landscape Part 1. Click the link below to access this report and others in the series.

<https://www.LivantaQIO.cms.gov/en/About/Publications>

Appendix C: Patient Tools and Resources

AHRQ's Question Builder App

The AHRQ Question Builder app helps patients and caregivers prepare for medical appointments. The app also includes a feature for taking photos of medical cards, pill bottles, and more, as well as access to patient educational materials. Learn more at the following link. <https://www.ahrq.gov/questions/question-builder/index.html>

Medicare's Care Compare Website

This consumer-friendly tool is designed to help patients find and compare different types of Medicare providers (like physicians, hospitals, nursing homes, DME suppliers and others). The helpful maps and filters make it easy to find providers for acute care, post-acute care, dialysis facilities, and more. Learn more by clicking the following link. <https://www.medicare.gov/care-compare/>

Taking Care of Myself: A Guide for When I Leave the Hospital

This helpful tool from AHRQ helps patients organize information about their medication, upcoming appointments, important phone numbers, and more. Access the 16-page document at <https://www.ahrq.gov/sites/default/files/wysiwyg/patients-consumers/diagnosis-treatment/hospitals-clinics/goinghome/goinghomeguide.pdf>

Your Discharge Planning Checklist

Because discharge planning is essential for patients to continue their recovery, ensuring they understand the plan is vital. This checklist is for patients and caregivers to use. It is designed to help them understand each step, ask questions throughout the planning stage, and make notes. Medicare advises using this checklist early in the discharge planning process. To download the checklist, click here:

<https://www.medicare.gov/Pubs/pdf/11376-discharge-planning-checklist.pdf>

Appendix D: Provider Tools and Resources

Chronic Care Management Toolkit

Chronic care management (CCM) helps with care coordination for patients with two or more chronic conditions. This toolkit includes information for healthcare professionals, community groups, and others. It includes tips for getting started, fact sheets, and educational materials to share with patients. Learn more at the link below.

<https://www.cms.gov/files/document/chronic-care-management-toolkit.pdf>

CMS's Guide to Reducing Disparities in Readmissions

From the CMS Office of Minority Health, this 46-page resource is for health care practitioners, leaders, and community partners. It is designed to drive change and deploy interventions that advance equity and reduce disparities in readmissions and associated health outcomes.

https://www.cms.gov/about-cms/agency-information/omh/downloads/omh_readmissions_guide.pdf

IDEAL Discharge Planning Implementation Handbook

AHRQ's Care Transitions from Hospital to Home: IDEAL Discharge Planning Implementation Handbook sets out a step-by-step method for care providers to develop an effective discharge plan. IDEAL is described below.

Access the IDEAL Guide to Patient and Family Engagement at

https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_1_IDEAL_chklst_508.pdf

Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation

This toolkit is based on acute-care systems, although the core processes, tools, and resources can be adapted for use in non-acute facilities. Download the 104-page booklet at

<https://www.ahrq.gov/sites/default/files/publications/files/match.pdf>

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