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A Primary Care Physician's Ideal Transitions of Care—Where's the Evidence?

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Reducing hospital readmissions is a national healthcare priority. Most of the interventions to reduce hospital readmission have been concentrated in the inpatient setting. However, there is increasing attention placed on the role of primary care physicians (PCPs) in improving the transition from hospital to home. In this article, a primary care physician's perspective of how inpatient and outpatient providers can partner to create the ideal care transition is described. Seven steps that occur during the hospitalization are highlighted: communicate with the PCP on admission, involve the PCP early regarding discharge planning, notify the PCP on hospital discharge, complete the discharge summary at time of discharge, schedule follow-up appointments by discharge, ensure prescriptions are available at the patient's pharmacy, and educate the patient about self-management. Another 7 are described as the role of the PCP and clinic staff: call the patient within 72 hours of discharge, ensure follow-up appointments with the PCP, coordinate care, repeat above until medically stable, create access for patients with new symptoms, track readmission rates, and track and review frequently admitted patients. Insights are offered on how the changing financial landscape can help support elements of this idealized transition-of-care program. *Journal of Hospital Medicine* 2013;8:472–477. © 2013 Society of Hospital Medicine

Across the country, hospitals are rolling out programs to reduce readmissions. These range from patient education around their disease process and medications, improvements in discharge planning, medication reconciliation, outpatient appointments scheduled prior to discharge, and follow-up phone calls, among others.[1,2] Several collaboratives such as Project Better Outcomes by Optimizing Safe Transitions[3] and Hospital Medicine Reengineering Network[4] have formed to test, study, and share lessons learned from these inpatient-based interventions. Because financial penalties thus far have focused on decreases in inpatient reimbursement by the Centers for Medicare and Medicaid Services (CMS), most of the interventions to reduce hospital readmissions have been concentrated in the inpatient domain. It is unclear whether new payment arrangements with CMS or commercial insurers, such as bundled payments and accountable care organizations (ACOs), will pressure primary care physicians (PCPs) to further develop outpatient-based interventions.

In this article, I provide a PCP's perspective of how inpatient and outpatient providers can partner to create the ideal care transition from hospital to home. Although others have conducted systematic reviews or surveys of interventions to reduce hospital readmissions,[2,5–7] I will start from a vision of an ideal transition, and then evaluate evidence supporting each step. I will also highlight areas where new reimbursement codes can help support an idealized transitions-of-care program.

ON HOSPITAL ADMISSION

Many PCPs consider the beginning of the care continuum to rest in the primary care practice and relationship. Over time, PCPs develop relationships with their patients, understanding the patients' values toward health and healthcare, learning their social support system and home environment, and documenting a clinical course of chronic diseases, including which therapies have and have not worked well. From a PCP perspective, it seems natural to be involved in care at the point of hospital admission. Some emergency departments (EDs) and hospital admissions offices have automated systems to email or fax PCPs admission notifications. Others rely on providers to make this connection.

Ideally, PCP communication would occur early in the hospitalization, especially for medically or socially complex patients, for 3 main reasons: (1) The PCP can offer insights on goals of care or therapies attempted in the past that may reduce unnecessary procedures, decrease length of stay, and improve patient satisfaction; (2) Reconciling medications that the patient should be taking and the list the patient reports may highlight noncompliance and trigger education around medication compliance prior to discharge; (3) Early PCP involvement may improve

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discharge planning efficiency, whereby the inpatient and outpatient teams agree on medical and social issues to be addressed for a safe discharge. Although there are no published studies that show communication early in the hospitalization impacts clinical outcomes, a national survey of hospitalists highlighted concerns about poor information exchange, particularly around medical history and outpatient medications, at the time of admission.[8]

As new financial models push healthcare providers to manage a population of patients under a global budget, inpatient and outpatient providers will need to communicate and collaborate at a level that is new for most institutions and providers.[9] Because early markers of success are based on financial savings, this means further reducing length of stay and transferring more care to the outpatient arena, tapping into community and home care resources. Involving PCPs early in the admission may help inpatient providers meet these goals.

DURING HOSPITALIZATION

Several publications from hospitalists have evaluated inpatient-based interventions to reduce readmissions and improve care transitions.[10–12] Table 1 summarizes 6 steps that can improve communication and collaboration.

AFTER HOSPITAL DISCHARGE

Immediately after hospital discharge, there are 7 steps that PCPs and their clinic staff can follow to support a safe transition from hospital to home. The literature supports several individual steps, but not the full package. I am proposing that primary care clinics adopt all 7 steps in an ideal transitions-of-care program.

Step 1: Telephone Call Within 72 Hours of Discharge

Many hospitals ask nurses or customer service staff to call patients immediately after hospital discharge. Call content ranges from reviewing discharge instructions and symptoms to satisfaction with hospital care. Even though a 2006 Cochrane review did not find a positive impact of hospital-based postdischarge phone calls on readmission rates,[13] recent studies among select populations found small but significant reductions.[14,15] Others have looked at fulfilling this role in the outpatient setting.[16,17] A recent systematic review of primary care clinic-based postdischarge phone calls showed no impact on readmission rates, but only 3 studies were included.[18] Health plan-initiated telephone calls to plan members after hospital discharge reported a 22% reduction in readmissions.[19,20] Because there is no standardization in telephone call content, reviews of inpatient-based and clinic-based interventions cited methodological challenges in drawing conclusions about impact.

Although education around disease process, lifestyle changes, and medication adherence can be effectively provided by staff from the hospital, clinic, or health plan, the outpatient clinic should assume primary responsibility for some components of the postdischarge call. First, if a patient does not have a follow-up appointment after discharge, the clinic nurse can schedule the appointment directly. Second, medication discrepancies after hospital discharge pose safety risks.[21–23] Although inpatient nurses may review discharge medications, it is the primary care nurse who can reconcile the discharge medication list with the prehospitalization medication list and identify discrepancies. The outpatient nurse has easier access to the PCP to address discrepancies. Third, the primary care nurse can provide education around "red-flag" symptoms for which to call the clinic and information on after-hours clinic access, an area that patients have specifically requested as standard after discharge.[24] If the patient reports new symptoms, the clinic nurse has easy access to the PCP for management advice, as well as the clinic schedule for an urgent appointment. Having the primary care practice house posthospitalization phone calls allows for more efficient troubleshooting of postdischarge issues.

In January 2013, CMS introduced new codes for primary care-based care coordination after hospitalization. Current procedural terminology (CPT) codes 99495 and 99496 can be used by PCPs who complete 2 steps: (1) document discussion with a patient or caregiver about care transitions within 2 days of discharge, and (2) have a face-to-face visit with the patient within 2 weeks or 1 week, respectively.[25] Reimbursement for these codes is substantial—3.96 work relative value units (RVUs) for 99495 and 5.81 work RVUs for 99496—considerably more than a level IV visit for complex follow-up care (2.43 work RVUs). Primary care practices may find that reimbursement for these care coordination codes helps cover additional costs of nurses, case managers, or social workers assisting with posthospital care. The

TABLE 1. Inpatient Interventions to Improve Care Transitions

1. Involve the PCP in discharge planning early in the hospitalization.[1]
2. Notify the PCP on hospital discharge.[44]
3. Ensure the discharge summary is available at the time of discharge.[44] Several elements should be included in all discharge summaries:[45]
   a. Home services ordered, home agency, timing of initiation of services.
   b. Medication changes.[21]
   c. Status of active problems at time of discharge.[11]
   d. Follow-up appointments, especially specialty follow-up.
   e. Tests pending at discharge or follow-up required after discharge (eg, follow-up CT scan in 6 months for incidental lung nodule).[11,46,47]
   f. Equipment ordered.
4. Schedule follow-up appointment with appropriate outpatient provider by discharge.[11,29]
5. Ensure new prescriptions or changes to prescriptions are available at patient's pharmacy and any needed insurance preauthorization has been approved.
6. Educate patient about disease process, medication adherence, lifestyle changes, and symptoms to monitor for after discharge.[22,48,49]

NOTE: **Abbreviations:** CT, computed tomography; PCP, primary care physician.

financial impact on primary care practices may increase if commercial insurers accept these CPT codes and reimburse at levels comparable to the CMS.

CMS approved reimbursement for posthospitalization phone calls despite mixed evidence on the impact of the intervention, presumably because it is perceived that early follow-up may lead to benefits that cannot be easily captured in research studies, and simply represents good patient care. Two challenges in showing an impact of these phone calls are lack of standardization and small sample size. However, implementation of the care-coordination CPT codes will require more standardization and potentially a much larger number of patients who receive posthospitalization phone calls. This allows for a much more robust evaluation of the intervention.

Step 2: Follow-up Appointment With PCP or Most Appropriate Continuity Provider

Early follow-up with an appropriate outpatient provider has been associated with reduced hospital readmissions for patients with congestive heart failure, chronic obstructive pulmonary disease, and psychiatric illnesses,[26–29] but this finding has not been consistent across all patient populations.[5,30] It is not well understood if the follow-up appointment needs to be within a specific time frame, especially if the patient is already being "touched" once by the system through the posthospitalization call. General consensus falls within 7 days for patients at moderate to high risk for readmissions.[31,32] Regardless of risk, follow-up visits must occur within 2 weeks of discharge to claim the CMS reimbursement for posthospitalization care coordination, and higher reimbursement is offered if it occurs within 1 week.

Step 3: Care Coordination

A nurse, social worker, or case manager partnering with the PCP on care coordination may improve the patient experience and outcomes.[17,24] Although the inpatient social worker or case manager may have helped address some housing, financial, home care, and durable medical equipment needs, often these issues are not completely resolved at discharge. There should be a seamless handoff between inpatient and outpatient care coordinators.

Although some primary care practices include social workers, case managers, or health coaches, many have general clinic nurses functioning in these roles. One way to help fund these roles is through the care coordination CPT codes as previously described. Another consideration, as the financial model for funding care across the care continuum changes, is to have inpatient social workers and case managers work jointly with inpatient and outpatient providers, following patients to the outpatient setting until their social needs are met. This arrangement is more feasible for integrated delivery systems or primary care clinics with contractual agreements with local hospitals, an emerging trend in markets across the United States.[33] Other resources for care coordination include health plan case managers and local community nonprofits. In 2011, CMS launched the Community-Based Care Transitions Program (CCTP), which will award up to $500 million in funding over 5 years to community-based organizations to assist Medicare patients with care transitions.[34]

One way of operationalizing care coordination, especially in primary care clinics that do not have an embedded social worker or case manager, is to offer a team-based appointment in conjunction with the physician postdischarge visit. A healthcare team member (nurse, experienced medical assistant, pharmacist) reviews hospital discharge records, educates the patient about the reasons for hospitalization and how to prevent readmission, performs detailed review of medications, follows up on any pending test results, reviews home care orders or durable medical equipment orders, and identifies any psychosocial issues that need to be addressed. All findings are documented in the patient chart and available for review at the beginning of the physician visit. With the team previsit in place, the physician can focus on the medical problems.

Step 4: Repeat Process Above Until Active Issues Are Stabilized

For some patients, steps 1 through 4 may need to be repeated until active medical and psychosocial issues are stabilized. Creating clinic infrastructure to support patients who may need to return weekly for titration of medications or monitoring of lab values until they normalize can prevent unnecessary ED visits. Patients with psychosocial issues will likely need longitudinal support, as these issues often take months to resolve.

Step 5: Create Access in Clinic for Patients With New Symptoms

Even after the first posthospitalization visit, patients may need to return to their PCP because of new symptoms or for active monitoring. In many parts of the country, PCP access is limited.[33] To meet patient demand for timely appointments, many primary care practices have piloted "advanced access scheduling," reserving the majority of appointments for same-day patient requests. However, evaluations show that the same-day appointment goals of advanced access are difficult to achieve for most practices.[35] Despite challenges to same-day access for the general clinic population, it is critical to create access for patients recently hospitalized, as many are at high risk for an ED visit or another hospital admission.

Step 6: Know Your Numbers

A basic tenet of quality improvement is measuring baseline performance and performance at intermediate

time points during an intervention.[36] A recent Cochrane review found that feeding back performance to physicians can lead to potentially important improvements in practice.[37] In an Institute for Healthcare Improvement how-to guide for improving care transitions, measuring readmission rates is 1 step in their Model for Improvement.[32] However, few primary care clinics are actively monitoring their readmission rates. One basic challenge is data availability. Primary care clinics affiliated with a hospital can obtain discharge and readmissions data from the hospital, but patients may also be hospitalized at other facilities. Insurers would be the best source of hospital discharge data, and some payors supply PCPs with risk-adjusted performance metrics.[38,39] As ACOs mature, primary care clinics can partner with payors to obtain data and begin trending their hospital discharge and readmission rates. In the interim, trending readmission rates at a single affiliated institution and filtering by service, discharge diagnosis, or payor may reveal areas for intervention.

Step 7: Know Your Readmitted Patients

Similar to knowing the primary care clinic's overall discharge and readmission numbers, it is also important to know the population of frequently readmitted patients. Even though some PCPs may be able to recall these patients by memory, it is important to review these patients' charts and identify preventable factors related to readmission, especially system-related factors. Conducting reviews can be time intensive and add new demands for busy PCPs. However, many clinics already conduct morbidity and mortality conferences and case reviews as part of improving patient satisfaction, service, and outcomes. Case reviews of frequently admitted patients can fall under these established activities.

IMPLICATIONS

In this vision of the ideal care transition, I am suggesting a shift in culture from a predominantly hospital-based program to a program that spans the care continuum and requires active participation and ownership from the PCP's team. It will require inpatient and outpatient providers to communicate early and frequently during the hospitalization, sharing patient information efficiently and working collaboratively as part of a larger team to meet the medical and psychosocial needs of the patient. This concept is not new, but has not been supported financially from payors.[1,9,40] Most PCPs operate on margins that cannot support additional PCP time to coordinate care for patients or staff to assist (although many PCPs believe this is the role of the primary care medical home).[33] Some payors agree that stipends to support infrastructure change are needed to improve patient outcomes.[17,38,39]

Even though every envisioned step does not require additional funding, new payment arrangements under ACOs and bundled payments may offer opportunities for PCPs to assume a larger role in care transitions and secure funding to pay for interventions. However, primary care practices must be positioned to negotiate favorable global payment agreements, be willing to assume risks associated with global payments, and prioritize management of medically and socially complex patients who are at risk for preventable ED visits and hospitalizations. PCPs who are not participating in ACOs or bundled payments, or those who are risk adverse, may be able to finance pieces of this vision with the new care coordination CPT codes supported by Medicare (and possibly commercial payors in the future). They may also partner with community groups participating in CCTP for additional support. Others focus on the long-term benefits of ACO-like structures rather than the short-term investments needed.[41]

Are all 14 steps proposed above essential? Without doubt, this vision will be difficult to fully operationalize and requires coordination and support from many distinct groups. Should all patients be offered a basic package of interventions, reserving the full package for those who are identified as highest risk for poor outcomes after hospital discharge? There is already some support around specialized interventions for patients at high risk for readmissions,[32,41] and risk prediction models have been introduced to identify these individuals.[42] Or should we approach this as a menu of interventions from which to choose, tailoring interventions to individual patient needs? These questions should be tested, as our experience in coordinating care across the continuum matures. With over 100 ACOs formed in Medicare alone[43] and many more with commercial insurers, our understanding in this area will grow in the next 5 years.

CONCLUSIONS

As cost containment measures in healthcare target preventable readmissions, hospitals and primary care physicians are increasingly encouraged to improve transitions along the care continuum. In this article, I offer 1 PCP's vision of the ideal transitions-of-care program from hospital to home. This article focuses on steps that can be taken by PCPs and their clinic staff; it does not address the role of outpatient specialists, home care agencies, or community support groups in care transitions. Operationalizing this vision requires commitment from the hospital and clinic leadership, as well as buy-in from front-line providers. More research is required to understand the marginal impact of each component of this vision, as well as the comprehensive package of interventions proposed, on patient outcomes. New financial models with payors and hospitals may make it easier for primary care clinics to test this vision. Current financial incentives are

likely still inadequate to fully align care along the continuum, but they offer some support for more PCPs to take an active role. The time has come to shift our traditional view of transitions of care from a hospital-centric set of interventions toward one that spans the entire care continuum and includes primary care physicians and their clinic staff as key partners.

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References

1. Silow-Carroll S, Edwards JN, Lashbrook A. Reducing hospital readmissions: lessons from top-performing hospitals. The Commonwealth Fund Synthesis Report. April 2011. Available at: http://www.commonwealthfund.org/Publications/Case-Studies/2011/Apr/Reducing-Hospital-Readmissions.aspx. Accessed January 30, 2013.
2. Boutwell A, Hwu S. Effective Interventions to Reduce Rehospitalizations: A Survey of the Published Evidence. Cambridge, MA: Institute for Healthcare Improvement; 2009.
3. Society of Hospital Medicine. Project BOOST. Available at: www.hospitalmedicine.org/BOOST/. Accessed January 30, 2013.
4. American Association of Medical Colleges. HOMERUN Executive Summary. Available at: https://members.aamc.org/eweb/upload/HOMERUN%20summary%202012.pdf. Accessed January 30, 2013.
5. Hansen LO, Young RS, Hinami K, Leung A, Williams MV. Interventions to reduce 30-day rehospitalization: a systematic review. *Ann Intern Med*. 2011;155:520–528.
6. Bradley EH, Curry L, Horwitz LI, et al. Contemporary evidence about hospital strategies for reducing 30-day readmissions. *J Am Coll Cardiol*. 2012;60:607–614.
7. Hesselink G, Schoonhoven L, Barach P, et al. Improving patient handovers from hospital to primary care: a systematic review. *Ann Intern Med*. 2012;157:417–428.
8. Pham HH, Grossman JM, Cohen G, Bodenheimer T. Hospitalists and care transitions: the divorce of inpatient and outpatient care. *Health Aff*. 2008;27:1315–1327.
9. McCarthy D, Johnson MB, Audet A. Recasting readmissions by placing the hospital role in community context. *JAMA*. 2013;309:351–352.
10. Kripalani S, Jackson AT, Schnipper JL, Coleman EA. Promoting effective transitions of care at hospital discharge: a review of key issues for hospitalists. *J Hosp Med*. 2007;2:314–323.
11. Halasyamani L, Kripalani S, Coleman E, et al. Transition of care for hospitalized elderly patients—development of a discharge checklist for hospitalists. *J Hosp Med*. 2006;1:354–360.
12. Villanueva T. Transitioning the patient with acute coronary syndrome from inpatient to primary care. *J Hosp Med*. 2010;5(suppl):S8–S14.
13. Mistiaen P, Poot E. Telephone follow-up, initiated by a hospital-based health professional, for postdischarge problems in patients discharged from hospital to home. *Cochrane Database Syst Rev*. 2006;(4):CD004510.
14. Kansagara D, Ramsay RS, Labby D, Saha S. Post-discharge intervention in vulnerable, chronically ill patients. *J Hosp Med*. 2012;7:124–130.
15. Kind AJ, Jensen L, Barczi S, et al. Low-cost transitional care with nurse managers making mostly phone contact with patients cut rehospitalization at a VA hospital. *Health Aff*. 2012;31:2659–2668.
16. Balaban RB, Weissman JS, Samuel PA, Woolhandler S. Redefining and redesigning hospital discharge to enhance patient care: a randomized control study. *J Gen Intern Med*. 2008;23:1228–1233.
17. Steele GD, Haynes JA, Davis DE, et al. How Geisinger's advanced medical home model argues the case for rapid-cycle innovation. *Health Aff*. 2010;29:2047–2053. .
18. Crocker B, Crocker JT, Greenwald JL. Telephone follow-up as a primary care intervention for postdischarge outcomes improvement: a systematic review. *Am J Med*. 2012;125:915–921.
19. Harrison PL, Hara PA, Pope JE, Young MC, Rula EY. The impact of postdischarge telephonic follow-up on hospital readmissions. *Popul Health Manag*. 2011;14:27–32.
20. Melton LD, Foreman C, Scott E, McGinnis M, Cousins M. Prioritized post-discharge telephonic outreach reduces hospital readmissions for select high-risk patients. *Am J Manag Care*. 2012;18:838–844.
21. Bell CM, Brener SS, Gunraj N, et al. Association of ICU or hospital admission with unintentional discontinuation of medications for chronic diseases. *JAMA*. 2011;306:840–847.
22. Kripalani S, Roumie CL, Dalal AK, et al. Effect of a pharmacist intervention on clinically important medication errors after hospital discharge. *Ann Intern Med*. 2012;157:1–10.
23. Lindquist LA, Go L, Fleisher J, Jain N, Friesema E, Baker DW. Relationship of health literacy to intentional and unintentional non-adherence of hospital discharge medications. *J Gen Intern Med*. 2012;27:173–178.
24. Cain CH, Neuwirth E, Bellows J, Zuber C, Green J. Patient experiences of transitioning from hospital to home: an ethnographic quality improvement project. *J Hosp Med*. 2012;7:382–387.
25. Fiegl C. Medicare finalizes physician pay for new care coordination benefit. American Medical News. November 12, 2012. Available at: http://www.ama-assn.org/amednews/2012/11/12/gvl11112.htm. Accessed February 8, 2013.
26. Sharma G, Kuo YF, Freeman JL, Zhang DD, Goodwin JS. Outpatient follow-up visit and 30-day emergency department visit and readmission in patients hospitalized for chronic obstructive pulmonary disease. *Arch Intern Med*. 2010;170:1664–1670.
27. Misky GJ, Wald HL, Coleman EA. Post-hospitalization transitions: examining the effects of timing of primary care provider follow-up. *J Hosp Med*. 2010;5:392–397.
28. Hernandez AF, Greiner MA, Fonarow GC, et al. Relationship between early physician follow-up and 30-day readmission among Medicare beneficiaries hospitalized for heart failure. *JAMA*. 2010;303:1716–1722.
29. Nelson EA, Maruish ME, Axler JI. Effects of discharge planning and compliance with outpatient appointments on readmission rates. *Psychiatr Serv*. 2000;51:885–889.
30. Kashiwagi DT, Burton MC, Kirkland LL, Cha S, Varkey P. Do timely outpatient follow-up visits decrease hospital readmission rates? *Am J Med Qual*. 2012;27:11–15.
31. Project BOOST. Tool for addressing risk: a geriatric evaluation for transitions. Available at: http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/PDFs/TARGET.pdf. Accessed February 3, 2013.
32. Rutherford P, Nielsen GA, Taylor J, Bradke P, Coleman E. How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations. Cambridge, MA: Institute for Healthcare Improvement; 2012.
33. Bodenheimer T, Pham HH. Primary care: current problems and proposed solutions. *Health Aff*. 2010;29:799–805.
34. Center for Medicare and Medicaid Innovation. Community-based Care Transitions Program. Available at: http://innovation.cms.gov/initiatives/CCTP/#collapse-tableDetails. Accessed February 8, 2013.
35. Rose KD, Ross JS, Horwitz LI. Advanced access scheduling outcomes: a systematic review. *Arch Intern Med*. 2011;171:1150–1159.
36. Langley GL, Nolan KM, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. 2nd ed. San Francisco, CA: Jossey-Bass Publishers; 2009.
37. Ivers N, Jamtvedt G, Flottorp S, et al. Audit and feedback: effects on professional practice and healthcare outcomes. *Cochrane Database Syst Rev*. 2012;(6):CD000259.
38. Agency for Healthcare Research and Quality. Policy Innovation Profile. Insurer provides financial incentives, infrastructure, and other support to stimulate provider participation in quality improvement collaborations. June 6, 2012. Available at: http://www.innovations.ahrq.gov/content.aspx?id=3641. Accessed February 8, 2013.
39. Chernew ME, Mechanic RE, Landon BE, Safran DG. Private-payer innovation in Massachusetts: The "Alternative Quality Contract." *Health Aff*. 2011;30:51–61.
40. Sokol PE, Wynia MK; AMA Expert Panel on Care Transitions. There and home again, safely: five responsibilities of ambulatory practices in high quality care transitions. American Medical Association; Chicago, IL; 2013. Available at: www.ama-assn.org/go/patientsafety. Accessed February 22, 2013.
41. Agency for Healthcare Research and Quality. Policy Innovation Profile. Medical center establishes infrastructure to manage care under capitated contracts, leading to better chronic care management and lower utilization and costs. October 3, 2012. Available at: http://www.innovations.ahrq.gov/content.aspx?id=3651. Accessed February 8, 2013.
42. Kansagara D, Englander H, Salanitro A, et al. Risk prediction models for hospital readmission: a systematic review. *JAMA*. 2011;306:1688–1698.
43. Centers for Medicare and Medicaid Services. More doctors, hospitals partner to coordinate care for people with Medicare: providers form 106 new accountable care organizations. Press release January 10, 2013. Available at: http://www.cms.gov/apps/media/press/release.asp?Counter=4501&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date. Accessed February 8, 2013.
44. Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA*. 2007;297:831–841.

45. Snow V, Beck D, Budnitz T, et al. Transitions of care consensus policy statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. *J Gen Intern Med*. 2009;24:971–976.
46. Roy CL, Poon EG, Karson AS, et al. Patient safety concerns arising from test results that return after hospital discharge. *Ann Intern Med*. 2005;143(2):121–128.
47. Moore C, McGinn T, Halm E. Tying up loose ends: discharging patients with unresolved medical issues. *Arch Intern Med*. 2007;167:1305–1311.
48. Kangovi S, Grande D, Meehan P, Mitra N, Shannon R, Long JA. Perceptions of readmitted patients on the transition from hospital to home. *J Hosp Med*. 2012;7:709–712.
49. Makaryus AN, Friedman EA. Patients' understanding of their treatment plans and diagnosis at discharge. *Mayo Clin Proc*. 2005;80:991–994.