



The Care Transitions Program is a national program that has embraced its mission to improve quality and safety at times of transitions or care “hand-offs” across settings for persons with complex care needs. Improving quality and safety during care transitions in our fragmented health care system where providers (e.g., hospitals, nursing homes, home care agencies, primary and specialty care clinics) operate independent from one another in “silos” with no formal mechanisms to ensure adequate communication or accountability poses significant challenges. Clearly a uni-dimensional approach will not suffice. Rather our program recognizes that a multifaceted strategy is needed and had taken action to address the problem from multiple angles, including supporting patients and their family caregivers, articulating the key roles and competencies for practitioners, developing and testing quality performance measures, creating new tools to identify medical errors, promoting the role of health information technology, and working directly with policy makers.

Our program further understands that accomplishing these goals requires the ability to function effectively at the interface between innovation and “real world” health care delivery. Few investigators have been successful in translating research into practice. We have developed a high level of credibility and trust from leaders of the nation’s exemplar delivery systems. This network of potential “end-adopters” have become integral to ensuring that the products of the Care Transitions Program are relevant and provide an immediate solution to the challenges that these end adopters face in improving quality and reducing cost, and is readily adoptable within the current constraints of health care financing.

Our work has been published in leading medical journals and presented at national meetings. However, evidence for the impact of this work on the field extends well beyond publications or presentations. Rather the true measure for success is whether this research has influenced health care delivery in this country. This body of work has been recognized by nearly every leading national quality improvement entity including the Institute of Medicine, National Quality Forum, The Joint Commission, the Centers for Medicare and Medicaid Services, the Medicare Payment Advisory Commission, the nation’s Quality Improvement Organizations (QIOs), the Institute for Healthcare Improvement, the Advisory Board, the National Transitions of Care Coalition, the American Board of Internal Medicine, the American College of Physicians, the American Board of Medical Specialties, the Society for Hospital Medicine, the American Medical Association, and the World Health Organization.

To date, 155 leading health care organizations have adopted the Care Transitions Intervention<sup>™</sup>. The National Quality Forum endorsed and subsequently re-endorsed the Care Transitions Measure<sup>™</sup>. for use in performance measurement and public reporting and over 3,000 organizations in 15 countries have requested permission for its use. To keep up with this demand, the measure is now available in 7 languages.

Key next steps for the Care Transitions Program include understanding how to improve comprehension of discharge/transfer instructions on behalf of patients and family caregivers and expanding our capacity to share our products with leading health care organizations nationwide