

Achieving Successful Transitions Along the Continuum of Patient Care

*A Symposium for Nurse Leaders,
Educators and Managers*

DRAFT

Symposium Summary & Next Steps

January 17, 2011

Prepared by
The Regional Employment Board of Hampden County



The Western Massachusetts
Nursing Collaborative
Advancing Nursing  *Addressing Critical Needs*



The Western Chapter of Massachusetts Organization of Nurse Executives

Achieving Successful Care Transitions Across the Continuum of Patient Care

One aspect of health care influencing both quality and cost is the effective transition of patients from one setting of care or one set of providers to another during an episode of care. Settings of care include hospitals, sub-acute and post-acute nursing facilities, the patient's home, primary and specialty care offices, community health centers, rehab facilities, home health agencies, hospice, long-term care facilities and other institutional, ambulatory and ancillary care providers. In each setting, multiple clinicians care for each patient, sometimes independently and other times as part of an interdisciplinary team. Improving care transitions has the potential to save lives, reduce adverse events and disabilities due to gaps or omissions in care, and reduce unnecessary costs.

Massachusetts Strategic Plan for Care Transitions (2010)

Overview

On December 10, 2010, over 135 representatives from 30 different organizations attended a day-long symposium focused on ***Achieving Successful Patient Care Transitions***.

The symposium was designed to provide attendees an opportunity to:

- Increase knowledge and understanding about the patient care continuum
- Identify innovative strategies that achieve successful patient care transitions
- Establish new collaborations to achieve successful care transitions in the region

Organizations from across the continuum of care were represented. The following types of organization and the number of different facilities attended. See Appendix 1 for a full list of symposium attendees

- Long Term Care 10
- Acute Care 6
- Primary Care 4
- Home Health 3
- Education 8
- Other 5

The symposium was sponsored by the Western Massachusetts Nursing Collaborative, the Massachusetts Senior Care Association and the Western Chapter of the Massachusetts Organization of Nurse Executives. The partner organizations involved focused on this area for several reasons:

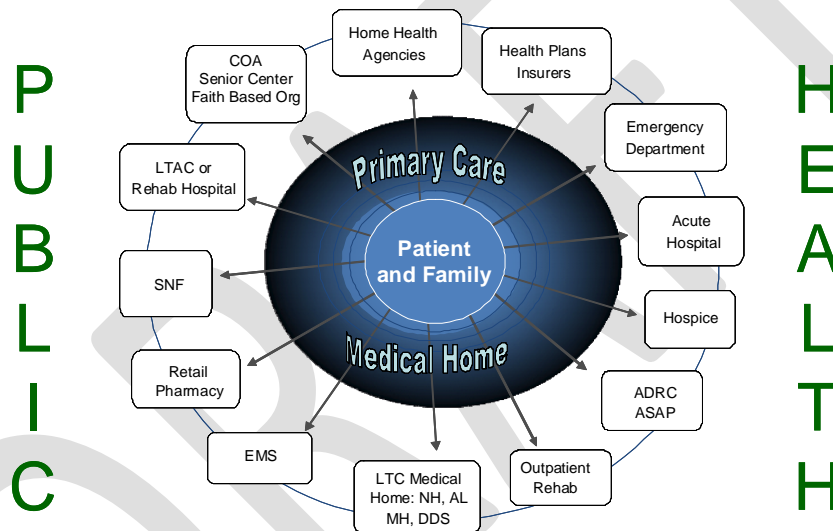
- Nurses are critical to improving patient care transitions and reducing hospital readmissions
- Healthcare reform will require cross-continuum collaboration to receive reimbursement
- New and seasoned nurses do not understand the patient's journey along the continuum of care
- New nurses not prepared to work in different care sites

These organizations will use the strategies and ideas generated to set the region's nursing agenda and update the 2008 Western Mass Nursing Workforce Strategic Plan.

Massachusetts Strategic Plan for Care Transitions

Keynote speaker Dr. Alice Bonner presented the Massachusetts Strategic Plan for Care Transitions. The vision is for care in Massachusetts to be organized around regions and communities, with integrated and coordinated systems of care across settings, and where flow of patient information is seamless and secure among all of a patient’s providers, insurers and patients themselves. She notes that in order to accomplish this transformational change, the Massachusetts healthcare community will require collaboration, effective partnerships and commitment to a paradigm shift. Ultimately, this work should result in the creation of a patient-centered care model delivered to populations that encompass the entire continuum of care. The care transitions model below provides a framework for ongoing discussion.

Model for Care Transitions Infrastructure



Dr. Bonner provided an overview of the barriers to effective care transitions:

Structural Barriers	Procedural Barriers	Performance Measurement and Alignment
<ul style="list-style-type: none"> • Lack of integrated care systems • Lack of longitudinal responsibility • Lack of standardized forms and processes • Incompatible information systems • Lack of care coordination and team-based training • Lack of established community links 	<ul style="list-style-type: none"> • Ineffective communication • Failure to recognize cultural, educational or language differences • Processes are not patient-centered nor longitudinal 	<ul style="list-style-type: none"> • Underuse of measures to indicate optimal transitions • Compensation and performance incentives not aligned with care coordination and transitions • Payment is for volume of services rather than incentivized for outcomes

Innovative Care Transition Programs

Laurie Herndon, Director of Clinical Quality at the Massachusetts Senior Care Association, provided a detailed overview of the STAAR and INTERACT II projects designed to reduce hospital readmissions.

STAAR - State Action on Avoidable Re-hospitalizations: An initiative of the Commonwealth Fund and the Institute for Healthcare Improvement (IHI) in MA, MI, OH & WA

- According to the IHI website: STate Action on Avoidable Rehospitalizations (STAAR) initiative aims to reduce rehospitalizations by working across organizational boundaries in four states — Massachusetts, Michigan, Ohio, and Washington — and by engaging payers, state and national stakeholders, patients and families, and caregivers at multiple care sites and clinical interfaces. Delivering high-quality health care requires crucial contributions from many parts of the care continuum, and effective coordination and transitions between providers and between care settings. In the hospital setting, poor coordination of care often results in rehospitalizations, many of which are avoidable. At the core of this challenge is improving care in the “white spaces” between settings of care, promoting enhanced “system-ness” in a fragmented environment
- The STAAR project is based on the work of Dr. Eric Coleman and the care transitions model he has developed. The model is based on four principles designed to improve care transitions and reduce hospital readmissions:
 1. Perform Enhanced Admission Assessment for Post-Hospital Needs
 2. Provide Effective Teaching and Enhanced Learning
 3. Conduct Real-Time Patient and Family-Centered Handoff Communication
 4. Ensure Post Hospital Care Follow-Up
- For more information:
<http://www.ihl.org/IHI/Programs/StrategicInitiatives/STateActiononAvoidableRehospitalizations/STAAR.htm>

INTERACT - Interventions to Reduce Acute Care Transfers: An initiative of the Commonwealth Fund in MA, NY & FL. The interventions include clinical and educational tools and strategies for use in every day practice in long-term care facilities.

- According to the INTERACT II website: INTERACT II is designed to improve the early identification, assessment, documentation, and communication about changes in the status of residents in skilled nursing facilities. The goal of INTERACT II is to improve care and reduce the frequency of potentially avoidable transfers to the acute hospital. Such transfers can result in numerous complications of hospitalization, and billions of dollars in unnecessary health care expenditures.
- For more information: <http://www.interact2.net/>

The Impact of Cross-Continuum Teams In Hampshire and Hampden Counties

Cross-continuum teams from Hampden and Hampshire counties described their efforts to increase the success of patient care transitions.

Hampshire County

Kelli Barrieau, RN, BSN, HCS-D, COS-D, VNA and Hospice of Cooley Dickinson

Sally Crowther, RN, BA, The Overlook of Northampton

Geri Molaghan, RN, BSN, Cooley Dickinson Hospital

Cheryl Pascucci, GNP, Park Avenue Medical Associates, Inc.

Nancy Sunflower, RN, MS, Cooley Dickinson Hospital

Hampden County

Susana Hall, RN, BSN, MBA, Baystate Health

Sally Kaufmann, MS OTR/L Genesis Healthcare

Janice Fitzgerald, RN, MS, CPHQ, Baystate Health

Kathy Stezko, RN, Baystate Health Visiting Nurse Association

- To view team presentations please visit the REB's website:
http://www.rebhc.org/pages/healthcare_resources.html

Achieving Successful Care Transitions through Education

A panel comprised of the following individuals focused on different educational approaches to improving patient care transitions. An overview of each presentation follows.

Kathleen Scoble, BSN, MA, M.Ed, Ed.D, Elms College, MACN president

Lauren Meade, MD, Baystate Medical Center

Lisa Wolfe, BA, MFA, MSN, UMass Amherst

Sue Lesser, RN, MSN, Cooley Dickinson Hospital

Massachusetts Nurse of the Future Competencies

Kathleen Scoble provided an overview of the Massachusetts Department of Higher Education's Nurse of the Future statewide competencies for entry-level nurses.

- The competencies were designed to serve as a framework for educational curriculum in associate and bachelorette degree nursing programs to insure the nurse of the future will be proficient at a core set of competencies. The work occurred from 2006-2009.
- To view the complete Nurse of the Future competencies please visit:
<http://www.mass.edu/currentinit/documents/NursingCoreCompetencies.pdf>
- The purpose of the statewide competencies:
 - To develop a core set of nursing competencies to facilitate several initiatives
 - To develop a seamless continuum of nursing education
 - To develop a statewide transition into practice model
- The wording of the competencies is designed to be applicable across all care settings and to encompass all patient populations across the lifespan from neonate to older adult.
- The competency model consist of a description of the essential knowledge, skills and attitudes required for effective performance of a task or activity.

- Elements of nursing practice within the continuum of care are integrated throughout several competencies. There are 5 broad areas of nursing practice for achieving successful transitions along the continuum of care in which we find NOF competencies:
 1. Knowledge about the continuum of care
 2. Managing patient information and data
 3. Communication
 4. Working with Clinicians and Cross Continuum Care Teams
 5. Improving care processes and outcomes of care

- The Nurse of the Future competencies that integrate principles of transitional care include:
 - Patient-centered care
 - Quality
 - System-based Practice
 - Communications
 - Teamwork & Collaboration
 - Informatics & Technology
 - Evidence-based practice

- Competency based education (CBE) provides a way to help assure that learners of nursing are competent at the end of their nursing educational program.

- The key issue here, is that competency based education can provide the basis for establishing standards for nurse graduate learning and performance; and a framework for transition into practice.

The Baystate Tufts Medical Tracer Program

Dr. Lauren Meade, Associate Program Director of Medicine at Baystate Health described the Residency Tracer Rotation for second year medical residents. The program has been designed to improve patient care transitions.

- Dr. Meade's presentation can be found at the REB's website:
http://www.rebhc.org/uploadedfiles/residency_tracer_rotation_meade_112710_final.pdf
- The program includes a 2 week block rotation and uses a "follow-me home" model that requires the resident follow the patient to their next care destination, typically a long term care facility or home. During this time the resident is rounding with a team and sees 12 inpatients.
- The residents identified opportunities to improve the accuracy and clarity of medication lists, solve post discharge problems through improved communications, documentation and directives, increase patient understanding of diagnosis, clarify next steps with patients, etc.
- Dr. Meade expressed opportunity to use the "Follow me home" model across settings and disciplines, including staff nurses and nursing students. Dr. Meade facilitates the reflection session with residents.

Cooley Dickinson/UMass Amherst Dedicated Educational Unit (DEU)

Lisa Wolfe, UMass clinical assistant professor and Sue Lesser, Manager of Professional Development, described how the Nurse of the Future competencies have been integrated into the new nurse orientation and into the Dedicated Educational Unit. They are also integrating tools, resources and lessons learned through the STAAR initiative at Cooley Dickinson Hospital and their continuum of care partners.

World Café Brainstorming Session

The World Café is an innovative yet simple methodology for hosting conversations about questions that matter. To move the region forward in our collective ability to achieve successful patient care transitions, Bonnie Geld from Baystate Health and World Café facilitator to consider answers to the following questions:

1. What adjustments should be made in the practice setting to achieve successful care transitions?
2. What changes should be made to education to achieve successful care transitions?

The conversations that occurred linked and built on each other as people moved between groups, cross-pollinated ideas, and discovered new insights into the issues related care transitions. As a process, the World Café gave attendees many opportunities to discuss the questions, the answers and successful strategies with representatives from across the continuum. T

he following pages contain a summary of the ideas and discussion among symposium participants. The ideas are organized using the Massachusetts Strategic Plan for Care Transitions framework for action (see pages 9-11 for specific principles, goals and recommendations).

Question 1: Practice Setting Adjustments to Achieve Successful Care Transitions

Timely Feedback and Feed Forward of Information

- Pilot the MA Department of Public Health's universal transfer form
- Utilize easy-to use forms to capture all necessary patient data
- Standardize documentation and minimum data required (same document with same language used between units, facilities, clinicians)
- Call back numbers and contact information should be included with transfers
- Develop a regional list of resources in the community that could be available for patients, families and nurses

Cross-Continuum Teams

- Use cross-continuum teams to implement standardized forms and processes. Communications between all team members and facilities, need verbal handover
- Conduct multi-disciplinary meetings, including pharmacists, case workers, physicians, nurses, etc. Everyone has a role in a smooth transition
- Implement person-to-person warm handovers between settings
- Focus on RN to RN communications across the continuum
- Implement follow-up calls to post-acute facilities and to patients
- Standardized handover communications across access points
- Spend time building relationships and trust across facilities needed to implement standardized processes and forms. There needs to be reciprocal respect between institutions and clinicians.

Communications Infrastructure

- Standardize communication infrastructure and communications expectations across all care settings
- Medication reconciliation needs to happen. Clear/concise/reconciled information at every transition point, both internally and across settings
- Improved information systems for admission and discharge with the capacity to document early

- Create a ‘health file for life’ like they do with the DMV.
- The medical record belongs to the patient so all their providers should have access to information at all sites. Provide patients with electronic health records on thumb drive so they can take it everywhere with them
- Clarify HIPPA requirements – who can the providers talk to. When patient changes care settings update the HIPPA so family/friends, etc. can receive patient information
- Patient information should be available to the provider prior to the patient arrival
- There needs to be equipment to adequately evaluate patients in all settings and document
- Education to community about transitions in care and levels – it’s a process
- Public education campaign to understand the continuum of care (understanding of types of care such as palliative care). Alice Bonner’s idea of subway signs that illustrate successful care transitions.

Patient and Family Engagement

- Provide patient and family-focused care by engaging them as active participants in developing their own treatment plans. Assess patient and family as a whole to determine all needs for discharge at time of admissions. Determine patient preferences, lifestyle, cultural differences and ability to manage care.
- Take into consideration the need to incorporate extended family and friends into the plan of care. Schedule family input meeting to discuss discharge plan.
- Incorporate patient “teach back”
- Advanced care planning for every patient, every prescription, every time
- Plan for discharge upon admissions. Conduct a thorough assessment of patient on admission and then plan for care trajectory with the outcome in mind. Taking this approach should change our approach to using admissions and discharge nurses
- Identify and align needs throughout the patient stay
- Change the way we think about patients – consider the ideal outcomes for the entire stay and long term needs of patients
- Teach patient to know diagnosis, how to care for themselves
- Realistic conversations with patients – understand patient motivation and compliance
- Conduct learning assessments with patients to we understand how a patient learns
- Nurse leaders, managers and staff nurses need to challenge the current state of practice and make changes
- Adapt the INTERACT CNA tool currently being used in long term care – use it for patients and families
- Education should be provided for patients and their families within the setting they are in
- Ensure that patients and their families understand the patient care plan. Focus on health literacy by providing resources for various types of learners and encouraging patient advocacy. Nurses need to understand culture, religion and language needs

Accountability for Care

- There needs to be greater accountability across the continuum

Provider and Practice Engagement

- Look at current best practices such as systems and programs that are effective (STAAR, PACE) and are not dependent on payers
- Change discharge process so nurses can initiate patient process and education prior to physician sign-off

- Physicians need to be more involved in transitions of care and culture change
- New roles are emerging that both service and education need to be aware of:
 - Need to create transitions coordinator who may/may not be a nurse.
 - Need disease specific patient care coordinators
 - Need patient-centered medical home coordinator through PCP
 - Nursing needs to move away from being task oriented
- Everyone involved in the cross-continuum team needs to understand other care settings and the jobs of each team member. Job shadowing, mentoring, education all needed so individuals can “walk in the shoes” of each provider, in each setting. Only then will providers feel they can be accountable for their role in successful care transitions.

Incentives

- Provide RN incentives to achieve successful patient transition outcomes
- Are there financial incentives for nurses to achieve successful patient care outcomes since they are not a cost center and not a profit center?
- As Accountable Care Organizations (ACOs) are going into effect, there needs to be greater respect and recognition of all providers in all settings
- Insurance companies need to be involved in discussions
- Communicate the incentives to get the desired outcomes
- Readmissions funding will dictate how teams work across settings
- Create a more effective discharge system/process that is not dependent on one discipline (e.g., the physician)

Question 2: Educational Changes to Achieve Successful Care Transitions

Symposium participants were asked to consider the changes to education necessary to achieve successful patient care transitions. Suggested changes range from the way we educate nursing students, the continuing education of staff nurses, nursing faculty preparation and integration of interdisciplinary patient care teams.

Educational Content and Curriculum Changes

- Nursing school and staff nursing education curriculum should incorporate the Implications of the Patient Care and Affordable Care Act, including Accountable Care Organizations (ACOs), Medical Home, etc. Understanding the financial implications of hospital readmissions will help nurses understand the value of focusing on how to improve patient care transitions.
- Have nurse educators from across settings work collaboratively to create standard curriculum modules that can be used across all educational settings that focus on the critical elements of a successful care transition (e.g., like the Hartford’s geriatric curriculum modules), highlights the culture change required at admissions/discharge, etc.
- Educate nurses in the business of healthcare, including cost of patient care
- Incorporate patient teaching into the curriculum, “teach back” and help nurses learn how to teach to those who have low literacy, cultural differences, etc.
- Allow nursing students an opportunity to gain experience teaching. Consider offering opportunity to teach CNAs.
- Current model of education needs to move from skill base to competency base (what they are doing, not where they are)

- Create more collaboration between practice and educational settings, particularly when making curriculum changes.
- Teach students about the process of collaboration and the critical elements needed for success
- Utilize technology to aid/enhance student and patient education. Use Skype, Wii, telemedicine resources in the learning environment
- Redesign the curriculum to reflect critical thinking, independence, integrate knowledge in order to increase the independence of nursing and empower nurses to lead across the continuum
- Nursing students need exposure to all types of nursing roles
- Teach levels of patient care – individual, family, cohort
- There needs to be an assessment of the current pre-licensure programs to determine how to move them from skills-based to competency-based programs. What does that mean for the NCLEX exam?
- Do not teach episodic care – teach critical thinking (not tasks), continuum and transitions of care, trajectory of care, new framework for education, tie to licensure

Faculty

- Nurse faculty need to convey respect of all health care settings to their students
- Nursing instructors should be competent in all service lines and levels of care, with particular emphasis on geriatrics
- Need to assess clinical faculty quality and competencies to. Ensure that all clinical faculty are prepared to teach. There needs to be a paradigm shift to change our approach to clinical education. Ensure educators get more education to be good role models.
- Faculty need training to move the curriculum from a skills-based curriculum to a competency-based curriculum. Educators need to understand the Nurse of the Future competency framework (Knowledge, skills, attitudes) and need standardized assessment tools to determine when students are achieving different competency levels. This is not something that many faculty have skill and knowledge in.
- Nurse educators need to understand how to teach different learners, including young adults, career changers (e.g., older adults) and then teach nurses how to do the same
- Faculty need time to incorporate new ideas into the curriculum and time to attend educational sessions to keep pace with new industry developments
- Create incentives for faculty to engage students
- Encourage more team teaching, teaching rounds with chronic conditions

Clinical Education

- Create a tracer program for nursing students and staff nurses that allow them to follow the patient across the continuum. Consider incorporating into a nurse residency program
- Create practicums and clinical opportunities across the continuum to better understand the importance of all roles
- Increase the number of clinical placements in post-acute settings and the quality of the experiences
- Long term care for clinical placements and a DEU
- Incorporate “Teach back” into the curriculum
- Teaching is a priority – resource appropriately
- Provide students with additional one-on-one time with patients (meaningful clinical experiences)
- RN’s at bedside are stipened educators
- Revisit RN educator ratios to nurses on units

- Create job shadowing opportunities to understand different roles involved in cross-continuum team
- Understand the value of residency programs and expand residency opportunities
- Look to expand the use of Dedicated Education Units (DEUs) in all types of setting. Learn from acute care experience and help to translate to other settings such as long term care.
- Create more opportunities for internships and job shadowing

Staff Nurses

There is general consensus that seasoned nurses need continuing, lifelong education to maintain a current and relevant practice. Staff nurses need to better understand the continuum of patient care and respect these other care settings, particularly those who work in acute care.

- Employers must recognize the need for nurses to have expertise in the continuum. There needs to be some demonstrate of the value of this education, such as in STAAR impact on reduced readmissions. This education should be considered professional development.
- Incorporate “Teachback”
- Incorporate the Nurse of the Future competencies into the practice setting
- Increase RN knowledge about what is available for patients along the continuum and within the community (i.e., public health opportunities)
- Role model best practices and worst practices (actually just telling worst, not role modeling!)
- Dedicate time to learn
- Incentivize RNs and other healthcare professionals to learn
- Always base decisions on best practice and evidence based practices
- Create CEU guidelines that work and can be applied across continuum (e.g., standardized Teach Back forums)
- Change the language used and talk about transitions rather than discharge

Interdisciplinary Education

- Create an MD/nursing tracer program using the Baystate as a model
- Provide opportunities for real life perspective in education. For example, sponsor Wed evening discussions to bring multi-disciplinary teams to table to learn about cases together
- Identify competencies for the different roles – find commonalities among different health providers and teach together (look at IOM competencies for healthcare workers)
- Get physicians involved in transitions in care and cultural changes in nursing education
- Think about various titles and be respectful of these different types of positions
- Teach about interdisciplinary discharge
- Teach communication and collaboration across roles and disciplines of setting
- Integrate cultural diversity into education across roles and continuum

Massachusetts Strategic Plan for Care Transitions and Western Mass Strategies

The Massachusetts Strategic Plan for Care Transitions offers seven principles, goals and state recommendations for action. The table below provides a summary. The table also offers potential strategies that could be implemented by the Western Mass Nursing Collaborative and its partners.

Please note that the strategies are in draft format. It has not been determined whether there is evidence to support their impact on increasing successful care transitions.

Care Transitions Principles & Goals	State Recommendations	Potential Western MA Strategy
<p>1) Timely feedback and feed forward of information through standardized care plans/transition records or other formats are essential to improving care transitions and reducing unnecessary costs</p> <p><i>GOAL: Care transitions will include electronic or hard copies of standardized forms for data transfers</i></p>	<ul style="list-style-type: none"> - Standardized, minimum data set & forms - Cross-continuum teams - Enhanced early post-acute care follow-up 	<ul style="list-style-type: none"> • Facilitate the development of cross-continuum teams • Facilitate interdisciplinary, cross-continuum team interaction/learning • Communicate minimum data set for effective care transitions
<p>2) Communication infrastructure should support efforts to improve care transitions</p> <p><i>GOAL: all health care systems will be aware of and adhere to a set of standards for communication around care transitions adopted by the HCQCC. Communication will honor and value the patient's wishes</i></p>	<ul style="list-style-type: none"> - Medication tracking - Contact information provided - Living database - HIPPA compliance 	
<p>3) Patient and family engagement is essential to improving care transitions</p> <p><i>GOAL: Patients and families/caregivers will be active participants in developing their own treatment plans. Providers will engage patients/caregivers in order to get an understanding of patient preferences and will insure they have an understanding of the treatment plan and next steps.</i></p>	<ul style="list-style-type: none"> - Patient-centered feedback - Patient and/or patient advocate representation 	<ul style="list-style-type: none"> • Host How-To “Teach Back” Session • Support public education campaign to change perception of continuum & role of nursing

Care Transitions Principles & Goals	State Recommendations	Potential Western MA Strategy
<p>4) Accountability for care during a transition remains with the sending set of providers until the receiving set of providers acknowledge responsibility for the care of the patient</p> <p><i>GOAL: There will be continuity of care from one set of providers to another across care transitions. Lapses in care during transitions will be eliminated</i></p>	<ul style="list-style-type: none"> - Longitudinal Accountability - Handoff responsibility - Identifiable provider 	<ul style="list-style-type: none"> • Host Continuum of Care or Successful Transitions 101 to educate faculty, staff, etc. about the different roles, responsibilities, etc. • Implement Tracer Program for nursing and interdisciplinary education
<p>5) Provider and practice engagement are essential to insuring safe, effective transitions</p> <p><i>GOAL: Providers will have a clear understanding of the Joint Principles published as the Transitions of Care Consensus Policy Statement and will assume a shared responsibility along with other entities such as hospitals, nursing homes, home health agencies, hospices, community health and consumers in the community for adopting and advancing any of these principles selected by Massachusetts for implementation</i></p> <p><i>http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2710485/</i></p>	<ul style="list-style-type: none"> - Education - Best practices - Mentors 	<ul style="list-style-type: none"> • Document successful patient transitions (leverage DPH project, STAAR, INTERACT) <ul style="list-style-type: none"> - Standardized curriculum - Role modeling - Case studies • Publicize best practice care transition models (Naylor, Coleman, RED, STAAR, etc.) and nurse-led innovation that leads to reduced costs and improved patient care • Support the creation of new nursing clinical education models, including nursing residency programs, internships that focus on the continuum of care • Advocate for LTC Dedicated Educational Unit • Increase the number of clinical placements in post-acute settings and the quality of the experiences • Support the dissemination and integration of the Nurse of the Future competencies into all healthcare facilities and schools of nursing • Offer Faculty Training on Developing Competency-Based Curriculum

Care Transitions Principles & Goals	State Recommendations	Potential Western MA Strategy
<p>6) Standardized process and outcome measures, based on nationally endorsed measures when available will be used to assess improvements in care transitions</p> <p><i>GOAL: Massachusetts will implement and track outcome measures related to care transitions</i></p>	<ul style="list-style-type: none"> - Collaboration with expert panel on performance measurement 	
<p>7) Payment reform should evolve over time towards an approach that aligns the incentives of providers, insurers and patients to maximize accountability for and minimizes adverse events associated with care transitions</p> <p><i>GOAL: Provide input into the discussions on new payment models that will support accountability for safe and effective care transitions within the context of statewide payment reform. Remove silos and provide care to populations, within regions or communities.</i></p>	<ul style="list-style-type: none"> - Incentive alignment - Data Transparency 	