Questions to Guide Listening Session #1 for the June 2023 Theme-Based Meeting:

Improving Management of Care Transitions in Population-Based Models

Topic: Relationship between Payment Features and Care Transition Innovations

Monday, June 12, 1:10 p.m. – 2:40 p.m. EDT

Listening Session Subject Matter Experts (SMEs):

- ***Cheri A. Lattimer, RN, BSN,*** Executive Director, National Transitions of Care Coalition
- ***Diane Sanders-Cepeda, DO CMD***, Senior Medical Director, UnitedHealthcare Retiree Solutions
- ***Diane E. Meier, MD, FACP,*** Founder, Director Emerita and Strategic Medical Advisor, Center to Advance Palliative Care (CAPC)

Committee Discussion and Q&A Session
To assist in grounding the Committee's discussion, the questions for the presenters will focus on the following areas.

A. Efficacy of Care Transition Management Activities and Care Transition Payment Approaches

B. Impact of Managing Transitions to Palliative Care, Hospice, and End-Of-Life Care

C. Post-Acute Care (PAC) and Long-Term Services and Supports (LTSS) Provider Care Delivery Innovations and Payment Features to Improve Care Transition Management

After each SME provides an 8-10-minute presentation, Committee members will ask the presenters questions.

The questions below are sample questions that Committee members may ask.

1. What activities are most important for improving care transition management between post-acute and long-term care settings for high-risk patients? What payment models best encourage providers or other entities to engage in these activities?

    a) What are some conditions or procedures where improved management of care transitions between settings could potentially have the greatest effect on quality, patient experience, and total cost of care for high-risk patients?

    b) Are there existing financial incentives, such as payments for chronic care management and transitional care management, that could be leveraged to support improved management of care transitions between settings?

    c) Does effectiveness of provider and entity activities vary by the types of care settings involved or the direction of the transition?

d) How can care transition management improve the quality of care for patients with health-related social needs?

2. How can Alternative Payment Models support care transition management in ways that disincentivize low-value care, improve quality and reduce total cost of care?

   a) What should be the primary goals for acute care, primary care, skilled nursing facilities and other types of providers engaged in managing care transitions between settings and levels of care?

   b) What factors in care transitions to palliative or end-of-life care contribute to low-value care? How can Alternative Payment Models disincentivize these patterns in care?

   c) How should the quality of end-of-life care transitions be measured? What outcomes reflect patient-centered, well-coordinated care? What outcomes reflect low-value care or poor quality-of-care?

   d) How can Alternative Payment Models improve patients' experiences in care transitions from curative to palliative care? What are the limitations of current payment models' support for patient-centered end-of-life care?

3. What post-acute care transition management innovations have shown to be most effective in improving patient outcomes and reducing spending on low-value care? How should payment models be designed to encourage the widespread adoption of these innovations?

   a) What are the specific barriers to improving care transition management in post-acute care settings?

   b) What resources or infrastructure, such as health information technology, do post-acute care providers need to improve care transition management?

   c) What are the ideal roles of acute-care and post-acute care providers in care transition management?