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Nursing Care Management
Influence on Bundled Payments

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Fragmented and uncoordinated care is the third highest driver of U.S. healthcare costs. Although less than 10% of patients experience uncoordinated care, these patients represent 36% of total healthcare costs; care management interaction makes a significant impact on the utilization of healthcare dollars. A literature search was conducted to construct a model of care coordination for elective surgical procedures by collecting best practices for acute, transitions, and post-acute care periods. A case study was used to demonstrate the model developed. Care management defines care coordination as a model of care to address improving patient and caregiver engagement, communication across settings of care, and ultimately improved patient outcomes of care. Nurse-led care coordination in the presurgical, inpatient, and post-acute care settings requires systems change and administrative support to effectively meet the goals of the Affordable Care Act of reducing redundancy and costs while improving the patient experience. Nursing is the lynchpin of care management processes in all settings of care; thus, this model of care coordination for elective surgical admissions can provide nursing care management leaders a comprehensive view of coordinating care for these patient across settings of care during the predetermined time period of care. As bundled payment structures increasingly affect hospital systems, nursing leaders need to be ready to create or improve their care management processes; care coordination is one such process requiring immediate attention.

Case Study

Mrs. Allen was a 73-year-old female patient who was admitted for a total knee replacement. She had experienced pain and swelling in both of her knees for 14 months. She was now experiencing increasing pain and weakness, and 4 months ago became unable to take her 7-year-old Schnauzer on his daily six-block walk in the neighborhood. She had previously been able to care for her home and garden with minimal assistance from her son and his family, who lived 7 miles from her home. She had seven stairsteps to her front door and no stairs within her one-level home. She was now unable to safely transfer into her step-in bathtub. Her medical history included hypertension, diabetes mellitus Type II, and obesity, with a body mass index of 32. She had not had a major surgery before but had a recent emergency department (ED) visit for swelling and pain. When she met with her surgeon, she thought she would need 2 weeks of home healthcare but would be able to return to caring for herself shortly after recovery. She did not intend to be admitted to a skilled nursing or rehabilitation facility. She had Medicare A&B coverage and a supplemental insurance plan.

Introduction

Fragmented, uncoordinated care is the third highest driver of U.S. healthcare costs (Scheppach, 2014). Although less than 10% of patients experience uncoordinated care, these patients represent 36% of total healthcare costs; effective care management interaction makes a significant impact on the utilization of healthcare dollars (Owens, 2010). The Affordable Care Act (ACA) was designed to incentivize providers to organize coordinated care and focus on decreasing redundancy and costs across systems of care as compared with current siloed fee-for-service models of care (Kovner & Knickman, 2011).

Bundled payment models are one of the ACA initiatives developed to promote increased coordination and communication among providers as they cost share the care provided during an acute care episode. A bundled payment is fixed reimbursement payment for treatment of a preselected diagnosis or condition over a specific period of time, such as 30 days of care for an elective joint replacement (Centers for Medicare & Medicaid Services, 2014). Before bundled payments, multiple providers would bill Medicare for their part in a patient's acute care episode. Providers such as hospitals, post-acute care providers, and physicians would all bill according to the quantity of services they provided, leading to increased spending based on the *quantity* of services provided under the fee-for-service model. Under the fee-for-service model, systems or providers of care

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The authors and planners have disclosed that they have no potential conflicts of interests, financial or otherwise.

DOI: 10.1097/NOR.0000000000000309

were often from different networks and thus unable to share detailed patient records, plans, and goals, adding to fragmented and uncoordinated care. Under some of the new bundled payment model, one entity—typically the hospital or the medical provider—receives one payment for all services provided, is responsible to determine the most appropriate post-acute care services, pays for those and additional unintended services, and is responsible for outcomes over a specific time period. April 2013 brought the first of four bundled payment models to healthcare organizations. This model instituted payment for episodes of care in an arrangement that includes financial accountability to *quality* outcomes.

The purpose of this article was to define and describe the bundled payment model, to evaluate the effectiveness of care coordination and care management models that function within a bundled payment model, and to offer orthopaedic nurse care managers (CMs) a comprehensive model for decreasing readmissions and ED usage by coordinating post-acute care following episodic elective procedures.

Definitions

Bundled payment model: A single-payment system implemented by Medicare that places financial responsibility for healthcare on the providers and organizations that deliver healthcare and incentivizes them to deliver value-based care through effective care coordination.

Fee-for-service model: A model in which Medicare reimburses providers and organizations for covered services that are ordered and provided to the patient.

Post-acute care: Any medical care or services that help patients recover from illness, disease, or disability after discharge from an acute care facility.

Value-based outcome: An outcome that decreases healthcare costs, improves quality outcomes, and decreases variations in care by using standardized, evidence-based care processes that reduce variability and redundancy in care (*Harvard Business Review*; Cosgrove, 2013).

Care for Mrs. Allen Prior to Bundled Payment Models

In most states, care for Mrs. Allen would be systems focused, meaning that each system providing care would bill and be responsible for its part of her surgery or her recovery in a post-acute care setting, rehabilitation, skilled nursing, or home health facility; systems-focused care is also described a "silos of care." In this situation, the surgeon and the hospital system may have CMs who would evaluate Mrs. Allen prior to surgery, but most likely a CM would review utilization of services only once she was admitted to the hospital. Most likely, Mrs. Allen's healthcare system would include preadmission preparation for surgery and discharge planning as part of capitated payment structures. Such structures encourage hospitals to coordinate care and avoid delays in care or discharge.

In systems-focused care, the hospital system assesses for post-acute care needs and focuses on streamlining the discharge process. Upon admission, Mrs. Allen's care providers would most likely assess her ability to care for herself at home, her family's ability to participate in her recovery, and her possible need for a referral to other facilities. But the hospital's scope of responsibility has traditionally stopped after discharge. Once surgery is performed, Mrs. Allen would be monitored for functional progress to transfer and ambulate and for the ability to take her medications. As discharge neared, her team would assess whether she needed acute rehabilitation, skilled nursing, or a home health referral. Once she was discharged, the hospital would no longer be involved in monitoring her post-acute care functional outcomes.

Definition of Prospective Bundled Payments

Bundled payment plans were developed from diagnosis-related groups (DRGs), which were implemented in the 1980s to control costs related to episodic hospital admissions. Controlling the payment for hospital admission for surgery or needed care was a way to incentivize healthcare organizations to provide efficient and effective care to clinics (Centers for Medicare & Medicaid Services, 2014). Prospective bundled payment models provide either a fixed payment for an episode of care or case rates or pay for service based on a retrospective bundled payment for which payers share in any savings to Medicare. Trials of the bundled payment model are being conducted by the Center for Medicare & Medicaid Innovation Center; participating organizations across the United States will measure outcomes and determine whether this payment model is financially sustainable (Centers for Medicare & Medicaid Services, 2014). Capitated payments have financially incentivized providers to reduce waste and redundancy within individual hospital systems since the 1980s. With the new 30-, 60-, and 90-day bundled care payments across systems, responsible entities will now have incentive to be accountable to value-based outcomes of care regardless of where the patient receives care.

Systems of care will be incentivized to coordinate care in a way that uses the most appropriate post-acute care settings, avoiding the use of EDs and preventing readmissions within a set amount of time. Systems of care are incentivized to provide patients with the most appropriate resources, to communicate with all providers, and to focus each piece of post-acute care on improving patients' overall outcomes (Kovner & Knickman, 2011). "Bundled payment is touted as a viable option to meet payer and provider goals because of the potential improvements it presents over the Medicare fee-for-service system of reimbursement and the capitation model of payment" (American Hospital Association Committee on Research, 2010, p. 3). Bundled payment models are showing promise within individual systems of care and are likely to become a permanent part of

financing care across systems once the trials are complete. The standardization of bundled payments will impact every organization and specialty within and surrounding current and future systems of healthcare (Centers for Medicare & Medicaid Services, 2014).

Nursing Impact on Bundled Payments

Acute care nurse CMs impact bundled payments through care coordination, quality improvement efforts, effective patient teaching, utilization review, and cost containment (Lamb, 2013). These CMs will be on the front line of bundled payment implementation. "Care coordination is foundational to the health care reform goals of improving the quality of care for individuals and populations via the efficient and effective use of resources" (American Nurses Association, 2012, ¶1). Nurse CMs are positioned within nearly every acute care setting and have the knowledge to impact patient outcomes by working with physicians to reduce healthcare costs through implementing care coordination across healthcare systems.

To evaluate the basic level of registered nurse care or care management/coordination interventions necessary to improve acute care patient outcomes, reduce costs, and produce financial sustainability in a bundled payment model, a search was conducted to identify effective and ineffective care management interventions in acute care facilities. The search strategy included searching for the terms *acute care* and *transitions of care* in CINAHL and PUBMED with no start or end dates. Thirty-six articles were identified. Of those, 13 were selected for this review. The second search strategy included searching for the terms *bundled payments*, *care coordination*, and *healthcare costs* in CINAHL with no start or end dates. Nine articles were identified. Of those, four were selected for this review. Important to note is that prior to bundled payment models, most research on discharge outcomes was done within systems of care that did not receive bundled payments; they still used fee-for-service models. Most research focused on specific high-risk chronic illnesses and less on planned elective procedures.

A Case for Care Coordination

Current models of case management implemented before care coordination are episodic, siloed, and fragmented; they have not shown significant impact on reducing readmissions and decreasing healthcare spending (Robinson, 2010). Preparing for transitions between systems is essential for reducing uncoordinated care that leads to poor patient outcomes (Schectman, 2013).

Many high-risk patients undergo frequent uncoordinated transitions back and forth among acute hospital settings, long-term hospital settings, inpatient rehabilitation facilities, skilled nursing facilities, and home (with or without home care services). Patients and their families navigate a complex healthcare system during times of crisis, and many are at risk for poor outcomes due to lack of preparation and possible sporadic follow-up. Schectman (2013) suggests that care management has evolved from uncoordinated and fragmented case management to a care coordination model that uses highly trained care coordinators who work across systems of care rather than remain siloed within one institution. While working with patients throughout their hospital stay, care coordinators should also focus on improving handoffs among hospitals, post-acute care settings, and primary care providers. Voss et al. (2011) state that care transition interventions have significant potential to improve outcomes when the focus is on good cross-setting communication during discharge from an acute care setting.

Transforming Case Management into Care Coordination

Before there were care coordination models, there was case management. Case management is a process that determines patients' needs for services, finds appropriate public or private agencies to meet those needs, and helps patients to access or apply for services related to a specific episode of care (Robinson, 2010). Care coordination begins with an accurate patient, family, and community assessment that leads to a co-created plan of care (McDonald et al., 2010). New care management models in bundled payment models rely upon care coordinators to perform many activities such as planning, monitoring, coordinating, organizing, sharing, and facilitating across systems of care (Robinson, 2010). Naylor, Aiken, Kurtzman, Olds, and Hirschman (2011) offer key points to achieve the following goals of bundled payment models:

- Care coordination led by a trained nurse
- Client and family input in care planning
- Client and family agreement with assessment
- Shared decision making
- Comprehensive discharge planning
- Care coordination follow-up
- In-person care coordination home visits within 2 days
- Patient and family education
- Readiness for discharge
- Healthcare provider follow-up within 7 days

Actions Necessary to Implement Care Coordination

Financial Support for Healthcare Systems

Transforming the current model of case management into a care coordination model for all patients requires care coordinators with bachelor- or master-level training who can identify at-risk patients who would benefit from coordination while transitioning to post-acute care environments (Coleman et al., 2004). These identified high-risk patients entering the healthcare system for planned surgical procedures require preparatory, acute, and ongoing patient-centered care coordination to ensure cost containment, appropriate healthcare utilization, and positive health outcomes (Spiro, Lee, & Emanuel, 2012). The transition will require funding, which the ACA has allotted in various forms (Naylor et al., 2011).

Creating Patient and Caregiver Engagement at Discharge

Creating engagement during the discharge process starts with creating a shared care plan. Care coordinators create engagement by listening to the needs of patients and their caregivers and ensuring the plan of care is aligned to their abilities and goals. Successful care coordination starts with patients and their caregivers in mind. Popejoy (2011) states, "It is essential that health care team members include and actively work with older adults and their caregivers at the time of hospital discharge to reasonably assure that information and care needs are met" (pp. 62–63). Many case management models and disease management programs have failed because they do not call for asking patients and families specifically about their goals for discharge, which would engage the patients and their families to buy into and actively participate in the discharge planning process early in the patients' care. To improve patient engagement during the discharge process, Anthony and Hudson-Barr (2004)) found that patients want discharge planning to include specific comprehensive education of the following points:

- Dietary plans and restrictions
- Movement expectations and limitations
- Restrictions on activities of daily living
- Postoperative skilled nursing task management
- Treatment options
- Normal recovery process.

Transition communication between providers promotes better patient outcomes. Coleman et al. (2004) argue that:

> When practitioners in different settings operate independently with no common care plan, older patients may be adversely affected. Problems including conflicting recommendations regarding chronic disease self-management, confusing medication regimens with a high potential for error and duplication, lack of follow-up care and inadequate patient and caregiver preparation for receiving care at the next healthcare setting. Poorly executed care transitions can further lead to greater use of the hospital and emergency services, increasing healthcare costs. (p. 1817)

Care coordination is fundamental in promoting patient engagement, encouraging patients to become willing and successful partners in their care. Patients and caregivers should be informed about the risk factors associated with possible readmissions, such as accurate medication management, rigorous disease management, and contacting the appropriate healthcare providers early to prevent unnecessary complications (Coleman et al., 2004).

Using Risk Stratification Software

Risk stratification is one example of a tool available to assist healthcare providers with targeting patients for aggressive care coordination that requires a sophisticated electronic system. The American Nurses Association (2012) has stressed the importance of ongoing research into care transition models and techniques to identify best practices in delivering effective care coordination that focuses on patients and their caregivers as primary partners with the healthcare team.

Risk stratification has been used as a tool to ensure that at-risk patients are targeted early in their hospital courses and then followed by care coordinators. Baptist Hospital uses a stratification tool known as LACE: length of stay, acuity, comorbid conditions, and total ED visits. Since the implementation of LACE, the hospital has decreased readmission rates by 50% during the 90 days following an acute care admission (Gilbert, Rutland, & Brockopp, 2013).

Care for Mrs. Allen After Implementation of Care Coordination

Mrs. Allen contacted an orthopaedic surgeon, and before her scheduled appointment, she met with a nurse care coordinator. The coordinator completed an assessment of the patient's home and her social support and financial/insurance resources. Using the LACE tool, the care coordinator identified that Mrs. Allen was an at-risk patient. Once the care coordination assessment was completed, Mrs. Allen was assigned to a class that teaches patients what to expect before, during, and after surgery. Mrs. Allen determined that she was prepared to move forward and contacted the care coordinator with the names of the post-acute care vendors that she would use for a durable medical equipment (DME) and home health. She also provided the name of a skilled nursing facility as a backup. The care coordinator ordered the DME and had it delivered to the patient's home. Mrs. Allen was referred to the surgical scheduler and arranged a time for the operation. She presented herself to the preoperative area the day of her surgery, was prepared for surgery, successfully had her surgery, and remained on the orthopaedic floor until she was ready for discharge. The case coordinator reviewed the preoperative care plan and implemented the home health plan as appropriate after the first day of postoperative physical therapy. The patient was transitioned home with home health on Postoperative Day 2. Three days after discharge, the care coordinator contacted Mrs. Allen to determine whether she had any needs or questions. A post-acute standardized questionnaire was completed, and necessary changes in care were implemented. The care coordinator continued to contact Mrs. Allen on a weekly basis until she reached 90 days of care, and it was determined that she no longer required assistance for her knee replacement.

Limitations of Evidence

Care coordination is evolving throughout the United States. This evolution has seen significant changes in the utilization of the nurse CM. There is limited data about the care coordination roles and models most appropriate for patients planning elective surgical procedures. This lack of data was one of the most notable limitations of evidence in supporting this synthesis of evidence. The vast majority of the articles discussed in this synthesis are focused on care coordination models that impact

chronically ill patients and costs associated with current DRG payment models. There was limited evidence on the nurse-lead, team-based care coordination model for acute care initiated before hospital admission, during inpatient admission, and with subsequent home follow-up for elective procedures and what impact it would have on bundled payment plans and cost containment. Because clinical trials for bundled payments are in their second phase, minimal research data is available for cost containment in the setting of a bundled payment model.

Proposal

To prepare for the third and fourth phases of the current bundled Medicare trials, effective healthcare systems will require a shift from a crisis model to one focused on healthcare promotion, disease prevention, and transitional communication across systems. Healthcare providers need to work together across settings, creating lasting partnerships to ensure that healthcare dollars are spent without waste and duplication. One of the first steps to ensure positive patient outcomes and cost containment for elective surgery is to promote the implementation of care coordination prior to surgical intervention. Preprocedural assessment and evaluation by a trained nurse CM before scheduling and undergoing an elective surgery will ensure that patients are provided with the education, expectations, and equipment necessary to promote healthy outcomes (Naylor et al., 2011). During meetings with patients electing to have surgical procedures, nurses will complete detailed education regarding disease process, surgical expectations, recovery time frame, recovery needs, postoperative care, expected postoperative contact with care providers, family and patient expectations, and medication management. To prevent readmissions, the CM should assess the patient's risk and document such in his or her teaching and care coordination plan as outlined by Legrain et al. (2011):

1. Comprehensive chronic medication review
2. Education on self-management of disease
3. Detailed transition of care communication to outpatient healthcare professionals

The CM, the patient, and the patient's family then need to develop a discharge plan that encompasses a multitude of possible outcomes related to the patient's elected procedure and comorbidities. The plan should address inpatient rehabilitation options, long-term acute care hospitals, skilled nursing facilities, intermediate care facilities, home health care, outpatient therapies, DME, and vendors. Obtaining patient and family buy-in during this process is essential to obtaining positive patient outcomes. The patient and the family should be instructed that the hospital discharge plan will depend upon various patient circumstances at the time of transition, such as skilled nursing needs, ability to complete activities of daily living, family availability, and financial resources (Legrain et al., 2011). Once the patient is scheduled for the procedure, the CM will discuss the patient's post-acute care, including 2-week postsurgical visits, necessary consultations, primary care appointments, and 6- to 8-week follow-up appointments as appropriate (Legrain et al., 2011). The CM will actually schedule the follow-up appointments during this discussion and will call to remind the patient of these follow-ups as they near, confirming that there are no barriers to attending such as transportation issues, lack of family assistance, or cognitive deficits.

Opportunities for education will be available across the healthcare setting during the patient's surgical experience; providing information early in the process has been shown to be especially invaluable. Nurse CMs need to show patients the possibilities and need to engage them and their families in transition planning. Coleman et al. (2004) state that patients and their caregivers are the only cross-communication tools or links traditionally available in the current care transition setting. With a lack of continuity in healthcare providers, it is essential to teach patients to actively participate in their care. Coleman et al. (2004) state that CMs should empower and educate their patients to meet their own healthcare needs and ensure that their own healthcare wishes and status are communicated across systems. This engagement will serve to create an environment of patient- and family-driven care coordination and empowerment.

Once the patient has been admitted to the surgical intervention site, it is essential for the CM to continue to engage in care coordination with the patient and the family to promote health, provide ongoing education, and preserve continuity of care. To ensure that the patient is progressing toward the desired outcome(s), a transitions CM can also be part of the team. Transitions CM responsibilities include preparing for monitoring the patient from discharge through the 90 days of post-acute acre. Transitions CMs have contact with the in-hospital CM by telephone and in person on a regular basis—every 24–48 hours depending upon the patient diagnosis and prognosis. If the patient is not progressing toward the desired outcome(s), the transitions CM will work alongside the in-hospital nurse CM to intervene as appropriate on the patient's and family's behalf. Once the patient has met the milestones for discharge from the acute care setting, the transitions CM and the hospital CM will complete the patient handoff with the accepting providers and implement the appropriate discharge plan that was planned by the patient and his or her family prior to admission to the surgical site (Voss et al., 2011). The family and the patient should have on hand all essential personal items and DME as appropriate for the patient's postprocedural medical state. After the patient has successfully transitioned to the required post-acute level of care, the transitions CM will follow up in person within 24 hours and by phone after 1 week (Voss et al., 2011), as well as 14 days and 30 days out, unless increased frequency is indicated by patient condition (Naylor et al., 2011).

Conclusion

Nurse-led care management or coordination is essential in the elective patient population if bundled payments are implemented on a broad scale. Care management at inpatient hospitals needs to create systems of care that are transition focused within a medical home model, and care management must also focus on more patient-centered than systems-centered communication

and care coordination. The current healthcare model focuses heavily on crisis management and is at risk of being insufficient to handle the long-reaching consequences of a bundled payment method. Nurses need education to obtain the necessary competency to advocate for patients and families using care coordination, and they need support to pursue this advanced education.

The focus of healthcare providers and systems must be on patients and their caregivers. Empowering and engaging patients and families and providing comprehensive care coordination services present a unique opportunity to improve patients' health outcomes in post-acute care environments. With patients and their families at the center of focused healthcare education, there is an opportunity to partner with patients and reduce unnecessary healthcare spending and readmissions among the elective surgical patient population. The nurse CM will be at the heart of these transitions and will play an integral role in care transition education and planning prior to surgical interventions, ensuring that the post-acute care transition is both safe and appropriate for the patient.

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