

National Transitions of Care Standards and a Consensus Measures Crosswalk published by ACMA and Funded by Pfizer, Inc.

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published by ACMA and 15 collaborating organizations

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The American Case Management Association (ACMA) announces the first multi-setting, interprofessional National Transitions of Care Standards endorsed by an [Executive Steering Committee](#) composed of representation from payer, provider, and other organizations.

The ACMA Transitions of Care Standards were designed with input from 15 collaborating organizations representing 10 practice settings: acute care, primary care, ambulatory, home care and hospice, managed care pharmacy, healthcare pharmacy, primary care, long-term care, behavioral health and payers. Healthcare leaders from each of these practice settings formed the Executive Steering Committee. The collaboration was funded by Pfizer, Inc.

The standards include fundamental and aspirational benchmarks that can ensure successful and “leading practice” transitions. In addition, and unique to the release of these standards, “consensus measures” outline a means to assess a healthcare organization’s performance as they execute these transitions.

ACMA is an established leader and the largest Association representing healthcare system case management and transitions of care. The new standards reflect the industry’s focus on how a patient moves from setting to setting. The involvement of 10 practice settings and both payers and providers embodies ACMA’s long-standing collaborative philosophy and recognizes the interdependent nature of successful patient transitions.

Patient-centered, value-based models of care require both quality of care and cost accountabilities. “These Transitions of Care Standards are longitudinal in nature – recognizing the nature of a transition cannot be defined by one practice setting and both quality and cost need to be measured. Our Executive Committee created consensus measures that allow any of the practice settings, provider or payer, to crosswalk industry metrics to each standard,” says L. Greg Cunningham, CEO of ACMA. For the safety of patients, it is vital that each case management/transitions of care professional understands their care delivery system, the payer and their care partners that represent other interdependent continuum settings.

As stated by Executive Steering Committee member Dale Beatty, DNP, RN, NEA-BC Chief Nursing Officer & Vice President Patient Care Services at Stanford Health Care: “It is so important that we set the standards based on a shared vision, mission, and desired outcomes rather than a structure that is budget neutral. Case management has progressed from the days of discharge being the key purpose and single driver. Adopting the Standards will support and optimize care coordination models needed under value-based care. We should be bold in setting our standards. Each organization’s profile, volume, and acuity will vary, so structure may vary as well, but the standards should be the North Star.”

To learn more about how your organization can take the Transition of Care Standards self-assessment, visit <http://transitionsofcare.org>.

About ACMA:

Founded in 1999, the American Case Management Association (ACMA) is a national, non-profit, professional membership association, which strives to provide resources, solutions, and support for Case Management and Transitions of Care professionals. ACMA is comprised of more than 8,000 members nationwide and more than 30,000 healthcare subscribers to its case management and transitions of care education products, including nurses, social workers, physicians and other professionals affiliated with case management/transitions of care. Through a variety of educational conferences and networking events at both the state and national level, ACMA provides its members with numerous opportunities to develop their skills, grow in their profession and learn from the experiences and practices of fellow members.

For more information, visit <http://www.acmaweb.org>.

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