



June 21, 2012

Acting Administrator Marilyn Tavenner
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1588-P
P.O. Box 8011, Baltimore, MD 21244-1850.

Re: CMS Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates (CMS-1588-P)

Dear Acting Administrator Tavenner:

We appreciate the opportunity to comment on the proposed FY 2013 Acute Care and Long-Term Care Hospital Prospective Payment Rule.

The National Transitions of Care Coalition (NTOCC) is a non-profit organization of leading multidisciplinary health care organizations and stakeholders dedicated to providing solutions that improve the quality of health care through stronger collaboration between providers, patients, and family caregivers. The organization was formed in 2006 to raise awareness about the importance of transitions in improving health care quality, reducing medication errors, and enhancing clinical outcomes among health care professionals, government leaders, patients and family caregivers.

As you are aware, patients —particularly the elderly and individuals with chronic or serious illnesses— face significant challenges when moving from one care setting to another within our fragmented health care system. Poor communication during transitions from one care setting to another can lead to confusion about the patient’s condition and appropriate care, duplicative tests, inconsistent patient monitoring, medication errors, delays in diagnosis and lack of follow through on referrals. These failures create serious patient safety, quality of care, and health outcome concerns. NTOCC strongly supports several of the quality measures included in the FY2013 proposed rule that are aimed at promoting higher quality of care through improved care transitions.

3-Item Care Transition Measure (NQF #0228)

NTOCC strongly supports the addition of the “3-Item Care Transitions Measure” to the existing Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. NTOCC has long advocated that central to ensuring an effective transition from one care setting to another is the communication of clear and accurate information between providers, patients and family caregivers. In today’s health system, most patients and family caregivers are not encouraged to play an active role when a transition in their care occurs, even though they are often the only constants throughout the

transition. It is essential that the communication process prior to a transition be a collaborative one that engages the beneficiary and family care-givers and addresses barriers that impede that communication, such as health literacy level. Patients and family caregivers must have the necessary information and tools to effectively manage their own health in order to make the transition smooth, safe and effective.

The CTM-3 measure identifies the care processes— “understanding one’s self care in the post hospital setting, medication management, and having one’s preferences incorporated into the care plan¹”— that are critical to improving transitions and reducing avoidable hospital readmissions. The inclusion of this measure will help hospitals and providers assess whether they are adequately preparing patients to leave the hospital and identify areas for improvement. Most importantly, it necessitates hospitals to adopt a patient-centered approach to transitional care.

In considering further rulemaking, NTOCC also recommends including family caregivers into the transitions process in a more systematic way. Currently, family caregivers are not documented on medical records. This is a serious exclusion that must be rectified so family caregivers can become confident and capable members of their loved one’s healthcare team. This is especially true during transitions the patient and their caregivers are the only constants across settings.

Hospital-Wide Readmission Measure (Tentative NQF #1789)

As identified in the proposed rule, avoidable hospital readmissions can “result from poor quality of care or inadequate transitional care”. NTOCC has long advocated that in order to reduce avoidable hospital readmissions and improve health outcomes, transitional care quality improvements must be made a priority.

NTOCC strongly supports the proposed inclusion of a hospital wide readmission measure in the Hospital Inpatient Quality Reporting program. We agree that reporting a hospital-wide readmissions rate will be a more robust measure to identifying deficiencies in care. To fully understand where improvements to transitional care can be made, it is important that we look beyond a small subset of disease-related measures.

NTOCC agrees with the proposed rule that there are several models of care and interventions aimed at improving the coordination of care between care settings that have led to improved health outcomes and reduction in hospital readmissions. To assist medical providers, last year NTOCC released a [Compendium of Evidence-Based Care Transition Interventions](#) which provides a user-friendly centralized resource for providers to have access to all currently available evidence-based interventions and tools. A companion resource to the compendium is also available which highlights the [essential care transition interventions](#) identified from a cross-walk of the various models of care. These seven care interventions include: medications management; transition planning; patient and family engagement/education; information transfer; follow-up care; health care provider engagement; and shared accountability across providers.

The hospital-wide readmission measure is an important first step in identifying gaps in care and promoting quality of care improvements. NTOCC encourages CMS to continue to implement measures

¹ Coleman, Eric, MD, MPH. "3 item Care Transitions Measure- FAQ." The Care Transitions Program. The Care Transitions Program, 12 June 2012. Web. 13 Jun 2012. http://www.caretransitions.org/documents/CTM_FAQs.pdf

that incentivizes the adoption of quality care improvements focused on the essential care transition interventions.

Inpatient Psychiatric Facilities Quality Reporting Program

NTOCC also strongly supports the inclusion of the process measures HBIPS-6, Post-Discharge Continuing Care Plan Created, and HBIPS-7, Post-Discharge Continuing Care Plan Transmitted to the Next Level of Care Provider Upon Discharge, to the Inpatient Psychiatric Facilities Quality Reporting Program. The inclusion of these measures recognizes the importance of shared accountability as the transmission of the care plan to the next provider is as important as the creation of the care plan itself.

NTOCC strongly supports the concept of making certain that a health care team is responsible for the care of the patient at all times, assuming responsibility for the outcomes of the care transition process by both the provider (or facility) sending and the provider (or facility) receiving the patient. Process measures that are applicable to the “sending” provider confirming that key information has been sent to the intended “receiving” provider should be paired with process measures that are applicable to the “receiving” provider documenting that key information received has been acted upon. NTOCC applauds the inclusion of these two measures and believes that the same measure concept should be adopted in other Medicare quality incentive programs in all types of hospitals.

However, in regards to measure HBIPS-6, NTOCC recommends that patient lab results and pending tests be included in the care plans, in addition to the reason for the hospitalization, the principal discharge diagnosis, discharge medications, and the next level of care recommendations. Also, NTOCC recommends that the timeframe for transmittal of the discharge plan under HBIPS-7 be changed to “within one post-discharge day” from “by the fifth post-discharge day.” In order to ensure the continuity of care, key information needs to be communicated in a timely manner, and we believe that means within 24 hours after discharge.

Again, NTOCC applauds the inclusion of several key care transitions measures, and believes that with the added enhancements outlined above, the proposed rule will be an important step forward to improving patient outcomes and reducing unnecessary health related expenses.

Sincerely,



Cheri Lattimer
Executive Director