

**United States Senate Committee on Finance  
Hearing on “Delivery System Reform: Progress Report from CMS”  
February 28<sup>th</sup>, 2012  
Statement for the Record**

**Submitted by: National Transitions of Care Coalition, Executive Director Cheri Lattimer**

Chairman Baucus, Ranking Member Hatch, and other Members of the Committee, we thank you for holding this important hearing and appreciate the opportunity to submit a statement for the record. The National Transitions of Care Coalition (NTOCC) believes that as policymakers and health care providers strive to improve health care quality and patient safety, it is essential that the improvement of care transitions in our health care system is made a top priority.

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.

The problems resulting from poor transitions also lead to significant financial burdens for patients, payers, and taxpayers. For instance, unnecessary hospital readmissions are often a result from errors and poor communication made in transitioning patients. Nearly one in five Medicare patients discharged from a hospital—approximately 2.6 million seniors—is readmitted within 30 days, at a cost of over \$26 billion every year, with an estimated \$12 billion spent on preventable readmissions.<sup>i</sup> The Medicare Payment Advisory Commission (MedPAC) concluded in its 2009 Report to Congress that a large proportion of re-hospitalizations could be prevented by improving the discharge planning process and coordinating care after discharge.<sup>ii</sup> In fact, several evidenced models focused on improving care coordination have reduced 30-day readmission rates by 20-40 percent.<sup>iii</sup> Recently in January, the Journal of the American Medical Association (JAMA) published numerous studies and articles around the theme of hospital readmissions and care coordination, and several of those studies suggest that systems focused specifically on transitions of care improve hospital readmissions dramatically.<sup>iv</sup>

NTOCC strongly supports several of the current Centers for Medicare & Medicaid (CMS) demonstration programs that are focused on addressing gaps in transitions, particularly for patient populations that are at high risk for a poor transition. This includes the Community Based Care Transitions Program (section 3026 of the Affordable Care Act), which provides funding to test models for improving care transitions for high risk Medicare patients by using services to manage patients’ transitions effectively. Now with 102 sites participating in the demonstration across the country, the program will provide care transition services to nearly 700,000 Medicare beneficiaries in 40 states across the country. In addition, other

delivery reforms, such as the Medicare Shared Savings Program, have prioritized key activities, including team-based care, shared decision making, and development of a care plan, which are essential to effective care transitions. We echo Chairman Baucus' emphasis during the hearing on obtaining timely interim results from these demonstrations, and we encourage CMS to share data and results of these demonstrations as they become available so that highly effective strategies can be deployed in other care settings.

Additionally, NTOCC is encouraged by the focus on quality measures in payment programs which rewards activities that seek to address some of the failures that occur during transitions, such as the communication of clear and accurate information between providers, patients, and family caregivers. For example, last year, CMS issued the Hospital Inpatient Quality Reporting Program final rule, and the "3-Item Care Transitions Measure" was incorporated into the existing Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. 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 plan"—that are critical to improving transitions and reducing avoidable hospital readmissions.<sup>v</sup> 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. NTOCC strongly supports the inclusion of this measure for patients in the hospital, and encourages CMS to promulgate the measure in other care settings.

NTOCC believes that quality measures play a very important role in delivery reform. However, it is important that CMS work with pertinent stakeholders to ensure that there is a coordinated effort to reduce any financial or administrative burden that any new quality measures or requirements would pose on healthcare providers. The demands on primary care physicians and hospitals are likely to significantly increase while the Affordable Care Act is implemented, as more individuals will seek preventative care due to requirements that insurance companies must cover these services and almost 30 million individuals will become newly insured. Therefore, NTOCC encourages CMS to seek a balance between additional quality requirements on providers and what is necessary to encourage broader use of best practices and strategies for effective care transitions.

NTOCC believes that the transitions of care process should be a collaborative one that engages the beneficiary, family caregivers, and the entire care team. Case managers, nurses, pharmacists, social workers, and other medical providers play an integral role assisting with patient communication and information transfers. Furthermore, they can aid patients by providing support, advocacy, medication adherence assessment, motivational intervention, resource coordination, enhanced patient self-management, and care planning. NTOCC strongly supports the integrated care and team-based care models that many of the CMS demonstration programs are testing. Additionally, in order to promote shared accountability throughout the transition and among the care-team, NTOCC strongly recommends implementing process measures that are aligned between both the provider (or facility) sending and the provider (or facility) receiving the patient to ensure that key information received has been acted upon.

In addition, people with multiple chronic medical and mental health conditions are among the highest-risk patients most prone to harm from inadequate transitions. According to the American Hospital Association, "Research indicates that better integration of behavioral health care services into the broader health care continuum can have a positive impact on quality, costs and outcomes."<sup>vi</sup> NTOCC encourages CMS to continue to work towards incentivizing a more integrated care system which takes mental and behavioral health circumstances into account for higher quality, more streamlined care.

NTOCC supports the many provisions in the Affordable Care Act that are aimed at promoting care coordination and effective transitions, but believes that more can be done, and we encourage the Committee to consider more fundamental payment changes that target care transitions. In fact, MedPAC's June 2012 Report to Congress specifically highlighted that "given the evidence on transitional care to date, an established payment could be made to a care manager who would work with the beneficiaries during their hospitalization and as they move to the community or other setting."<sup>vii</sup>

With that in mind, last year, Congressmen Earl Blumenauer (D-OR) and Thomas Petri (R-WI) introduced the Medicare Transitional Care Act, which would provide Medicare beneficiaries that are at highest risk for hospital readmissions access to evidence-based transitional care services provided by an eligible transitional care entity, such as a hospital or skilled nursing facility. Payment for these services would be linked to performance metrics to ensure that interventions result in improved outcomes, which will ultimately lead to reductions in Medicare spending.

The transitional services defined in the bill align with NTOCC's "Seven Essential Intervention Categories" which highlights the essential care transition interventions identified from a cross-walk of the various models of care, such as the Care Transitions Intervention, Transitional Care Model, Guided Care Model, Project Re-Engineered Discharge and Better Outcomes for Older Adults through Safe Transitions, and Rush University Medical Center's Enhanced Discharge Planning Program, all of which have demonstrated improvements in both health outcomes and reduction in costs to the health care system. The legislation would foster the use of these and other evidence-based transitions of care models.

We encourage the committee to consider similar care-transitions-focused proposals going forward which will build on the progress made in the ACA, address the current gaps in care coordination, improve patient outcomes, and reduce unnecessary health related expenses both for struggling families and for Medicare.

NTOCC appreciates the opportunity to submit a statement for the record and looks forward to working with the Committee to strengthen our health care delivery system.

---

<sup>i</sup> The Community Based Care Transitions Program: The Centers for Medicare & Medicaid Innovation. Web. Center <http://innovation.cms.gov/initiatives/CCTP/>

<sup>ii</sup> Medicare Payment Advisory Commission. Report to Congress: Improving Incentives in the Medicare Program. June 2009. Web. [http://www.medpac.gov/documents/jun09\\_entirereport.pdf](http://www.medpac.gov/documents/jun09_entirereport.pdf)

<sup>iii</sup> Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates, Proposed Rule, Fed. Reg. Vol. 77, No. 92. 28110-28039 (May 11, 2012). Web. <http://www.gpo.gov/fdsys/pkg/FR-2012-05-11/html/2012-9985.htm>

<sup>iv</sup> Journal of the American Medical Association. Vol. 309.4 (2013): Print. <http://jama.jamanetwork.com/issue.aspx?journalid=67&issueid=926266&direction=P>

<sup>v</sup> 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](http://www.caretransitions.org/documents/CTM_FAQs.pdf)

<sup>vi</sup> "Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes." Trend Watch. American Hospital Association, n.d. Web. 11 Mar 2013. [http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CDIQFjAA&url=http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf&ei=JyY-Uaq1EIn20gHS4IGQDg&usq=AFQjCNGm1aGy2-3M\\_oTvB0N7l66Jz2jEUw&sig2=gPrXrlxW7jJ36uHYZ8XVUQ&bvm=bv.43287494,d.dmQ](http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CDIQFjAA&url=http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf&ei=JyY-Uaq1EIn20gHS4IGQDg&usq=AFQjCNGm1aGy2-3M_oTvB0N7l66Jz2jEUw&sig2=gPrXrlxW7jJ36uHYZ8XVUQ&bvm=bv.43287494,d.dmQ)

<sup>vii</sup> Medicare Payment Advisory Commission. Report to Congress: Medicare and the Health Care Delivery System. June 2012. Web. [http://www.medpac.gov/documents/Jun12\\_EntireReport.pdf](http://www.medpac.gov/documents/Jun12_EntireReport.pdf)