NTOCC®
NATIONAL TRANSITIONS OF CARE COALITION

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IMPACT NEWSLETTER

Advisory Task Force Goes to Washington . . .

There are many issues and viewpoints in the health care reform initiative. As the debate heightens and continues, NTOCC has chosen to focus on the one constant in health care — *the patient*.

Moving forward with that focus, NTOCC continues our work on one issue central to good outcomes and satisfaction for the patient and their caregivers: *Improving transitions of care*.

NTOCC's Advisory Task Force convened a meeting in Washington, DC, on October 20-21, 2009. NTOCC members met with 24 Senators, Representatives, and their staffers from their local congressional districts in their Washington, DC, offices.

This issue of IMPACT contains some of the important information shared and discussed on Capitol Hill to improve transitions of care.

Health Care Reform Moves to the Senate — Transitions of Care Issues Remain Critical Component

Advisory Task Force members visit with US Representative, Danny Davis.

From left: *Peggy Leonard, Case Management Society of America; Christie Travis, National Business Coalition on Health; US Rep. Danny Davis (D-Illinois-7th district); Vicky Wicks, sanofi-aventis; & Bill Reis, American College of Healthcare Executives*

Sharing with Congressional Staff and Policy Makers

The purpose of the meetings was to affirm that areas of proposed language in Senate and House Bills line up with the seven considerations below which NTOCC believes should be included in any health care reform plan.

1. Improve communication during transitions between providers, patient, and caregivers
2. Implement electronic medical records that include standardized medication reconciliation elements
3. Establish points of accountability for sending and receiving care, particularly for hospitalists, SNFists (physicians practicing in skilled nursing facilities), primary care physicians, and specialists
4. Increase the use of case management and professional care coordination
5. Expand the role of the pharmacist in transitions of care
6. Implement payment systems that align incentives
7. Develop performance measures to encourage better transitions of care

(See page 2 of this issue of IMPACT for complete document.)

How You Can Share With Friends and Colleagues

NTOCC developed two one-page briefing papers containing elements to help you share reasons why it is important that transitions of care be considered in health care reform.

In addition to the seven considerations, also available are "THE IMPORTANCE OF TRANSITIONS OF CARE IN ANY HEALTH CARE SETTING" and "WHAT DOES A GOOD TRANSITION IN CARE LOOK LIKE?" (Page 3 of this issue).

All NTOCC Associate Members and Subscribers are urged to download and print these resources and share them with your congressional delegates and others.

NTOCC Staff Calls on Congressman in DC

Cheri Lattimer, NTOCC Project Director and Debbie White, NTOCC Project Coordinator recently visited with their home state congressman, U.S. Representative Mike Ross, (D) 4th District, Arkansas.

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Improving Transitions of Care

The National Transitions of Care Coalition (NTOCC) is a coalition of 30 diverse organizations dedicated to providing solutions that improve the quality of health care with better collaboration between providers, patients, and caregivers. The term "transitions of care" connotes the scenario of a patient leaving one care setting (i.e., hospital, nursing facility, assisted living facility, primary care physician care, home health care, or specialist care) and moving to another.

In the U.S. health and long-term care system, many patients experience transitions of care.

- Between 41.9 and 70 percent of Medicare patients admitted to the hospital for care in 2003 in the U.S. received services from an average of **10 or more physicians** during their stay.[1]
- **In Arkansas**, among the total number of discharges (154,506 between ages 65 to 85+) of hospitalized patients aged 65 to 84, **23.05 percent are discharged to another institution**, and nearly **13.22 percent receive home health care**. In the 85+ age group, 45.98% are discharged to another institution and 13.48% receive home health care. [2]
- On average, patients 65 or older with two or more chronic conditions see seven different physicians within one year, accounting for **95 percent of Medicare expenditures**.[3]

Miscommunication during transitions of care can reduce the quality of care significantly, leading to:

- Medication errors, both overuse and sub-optimal use of prescription drugs **harm an estimated 1.5 million people** each year in the United States, costing the nation at least **$3.5 billion annually**;[4]
- Patient and caregiver **confusion** about patient's condition and appropriate care;
- **Lack of follow-through** on referrals; and
- Increased costs because missing test results, discharge summaries, referrals, and medication lists may require patients to schedule **redundant appointments** or may lead providers to prescribe **duplicative medications**.

NTOCC believes the following considerations are important to better transitions of care:

- Improve communication during transitions between providers, patients, and caregivers;
- Implement electronic medical records that include standardized medication reconciliation elements;
- Establish points of accountability for sending and receiving care, particularly for hospitalists, SNFists (physicians practicing in skilled nursing facilities), primary care physicians, and specialists;
- Increase the use of case management and professional care coordination;
- Expand the role of the pharmacist in transitions of care;
- Implement payment systems that align incentives; and
- Develop performance measures to encourage better transitions of care.

Learn more at www.NTOCC.org.

[1] E Fisher, *Performance Measurement: Achieving Accountability for Quality and Costs.* Paper presented at the 2006 Quality Forum Annual Conference on Health and Policy, Washington, DC (Oct. 2006).

[2] HCUP State Inpatient Database 2007, Agency for Healthcare Research and Quality (AHRQ) based on data collected by Arkansas Dept. of Health and Human Services.

[3] JL Wolff et al., *Prevalence, Expenditures, and Complications of Multiple Chronic Conditions in the Elderly*, Archives of Internal Med. 162: 2269-76 (2002).

[4] G Harris, *Report Finds a Heavy Toll From Medication Errors,* N.Y.Times (July 21, 2006) *available at* http://www.nytimes.com/2006/07/21/health/21drugerrors.html?ex=1189828800&en=be8e73b215716d8d&ei=5070.

About the National Transitions of Care Coalition

The National Transitions of Care Coalition (NTOCC) was formed in 2006 bringing together thought leaders, patient advocates, and health care providers from various care settings dedicated to improving the quality of care coordination and communication when patients are transferred from one level of care to another. Transitions in care include a patient moving from primary care to specialty physicians; within the hospital it would include patients moving from the emergency department to various departments, such as surgery or intensive care; or when patients are discharged from the hospital and go home, into an assisted living arrangements or into a skilled nursing facility. NTOCC is comprised of a diverse group of national associations and organizations addressing the critical issues surrounding transitions of care. NTOCC views transitions of care as a major challenge to health care delivery and realizes it can only be solved by breaking down the silos and barriers between different health care settings and working collaboratively for the good of the patient. Whether you are a patient, care giver, health care professional, policy maker or media representative, NTOCC can provide you with information and tools to better understand, and improve, transitions of care challenges.

The Importance of Transitions of Care in Any Health Care Setting
and
What Does A Good Transition in Care Look Like?

The National Transitions of Care Coalition (NTOCC) is a group of 30 diverse organizations dedicated to providing solutions that improve the quality of health care with better collaboration between providers, patients, and caregivers. The term "transitions of care" connotes the scenario of a patient leaving one care setting (i.e., between various units within the same hospital or a different hospital, nursing facility, assisted living facility, primary care physician care, home health care, or specialist care) and moving to another. Transitional care is a set of actions designed to ensure coordination and continuity.[1]

Miscommunication during transitions of care can reduce the quality of care significantly leading to medications errors, lack of follow-through on referrals, increased cost because of missing tests results, unnecessary readmissions, discharge summaries, referrals and medications list.

NTOCC has identified communication as the main driver for improving transitions of care. Below are six identifiable persons and elements which are key to an effective transition of care[2]:

- Sender: The health care professional who is *accountable* for the exchange of key information necessary of ensuring continuity of care
- Receiver: The health care professional who is *accountable* for the receipt of the key information (usually at the next care setting) shared by the sender about the patient undergoing transition.
- Key Information: Critical information (such as most up to date medical history, medications list, discharge summary, results of tests/procedures) available in a clear, complete and *timely* manner.
- Action: Obligations and tasks the receiver of the key information execute in a timely manner to maintain continuity of care and services for the patient.
- Verification: A necessary action by the Sender to ensure that the key information sent has been appropriately received and acknowledged by the intended health care professional.
- Clarification: A necessary action by the Receiver to ensure that transition information is clear and if concerns are present enables the Receiver to pose questions to the Sender, in order to proceed with appropriate patient care.

NTOCC believes a critical component of this communication of information is the dialogue between the healthcare provider and the one constant in a transition, the patient/and family caregiver/s:

- Good transitions of care require that the patient/family take responsibility to communicate as an important part of the health care team; providing such information as an accurate, up to date medication list , results of any tests done prior to next care setting and advance directives (If patients do not have one, it is strongly recommended that patients complete one).
- Patients and family caregivers should assume an active role during transitions to ensure that their needs are met. They should be encouraged to ask questions regarding the care they will receive in the next setting(s); clarify changes made to their medications, review and (if possible) practice completing their instructions prior to returning home, and know who to call for follow-up appointments or who to call if their condition worsens.

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[1] Paper by the National Transitions of Care Measures Work Group, *Transitions of Care Performance Measures*, 2008.
[2] H. Tahan, COMMUNICATION: A Key Strategy for Effective Transitions of Care, Case In Point (February and March 2009).