

# IMPACT NEWSLETTER

## NTOCC Paving the Way In Development of Transitions of Care Models for Improvement

Long before health care reform was signed into law, NTOCC was focused on breaking down gaps and barriers which prove to be hazardous for patients going through transitions of care.

NTOCC was pointing out that transitions of care is not a national issue, but a global issue. Enter reform passage and now the regulatory phase has begun.



It's time to define the starting points of change to this global issue ... change has to first begin in single hospitals, systems, clinics, and skilled nursing facilities and doors must be opened within our communities in order to break down some of the toughest barriers of all; barriers of competing services, barriers of non uniform discharge forms, barriers and gaps of time and manpower allotments.

Yes, change is sometimes encouraged through realization of enforcements, such as Medicare and Medicaid Reimbursements being tied to 30-day readmission rates.

Nevertheless, NTOCC is witnessing some great examples of providers reaching across the "aisle"... their streets, counties and cities of their communities and states.

Tremendous strides are taking place. Barriers are coming down, gaps are being identified and improvements are coming.

We salute these community "connectors". In this issue we share four unique providers who are defining the starting points of change.

## DEFINING CHANGE

### THE MIAMI PROJECT

FMQAI

"FMQAI is one of 14 Medicare Quality Improvement Organizations (QIOs) selected by the Centers for Medicare & Medicaid Services (CMS) to participate in the Care Transitions Project. The project's goal is to reduce unnecessary hospital readmissions that may increase risk or harm to patients and costs to Medicare.

The setting is Miami — a community moved to action. These healthcare providers identified discharge-related communication problems as barriers to the improvement of quality of care.

To show their commitment to improve care transitions, the collaborative members created a *Proclamation for Safe Care Transitions*. Opportunities, such as the Miami Collaborative, foster greater dialogue between health care organizations and could provide the necessary momentum to

drive the care transition initiatives forward and sustain improvement over time."

*Susan Stone, MSN, RN*

### TRANSITIONAL CARE CENTER

TALLAHASSEE MEMORIAL HOSPITAL

"The Tallahassee Memorial Healthcare Transitional Care Center will provide follow-up care, in a multidisciplinary clinic setting, for patients who have been recently discharged from the acute care setting and are clinically stable. The target population is patients without an established outpatient medical home."

*Dean Watson, M.D.*

### THOMAS JEFFERSON UNIVERSITY HOSPITAL, TRANSITION OF CARE INITIATIVES

PHILADELPHIA, PA

Thomas Jefferson University Hospital began an anticoagulation program because



anticoagulants are one of the top five drug classes associated with patient safety incidents.

Step One of the plan was gaining support of Hospital leadership.

Step Two started on July 13, 2009, with 1,300 patients with knee and hip procedures receiving anticoagulation therapy,

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*Continued from Front*

managed from the day of surgery to the end of medication therapy by ONE single program:

*An interdisciplinary orthopedic team of both inpatient and outpatient surgeons, nurse practitioners, case managers, physician assistants, pharmacists, physical therapists, and visiting nurses.*

Clinician responsibilities were assigned from post-op day zero through six weeks. Now under development is a similar Urology Transition of Care Program.

**Patrice Miller, MSN, MBA**  
**Lynda Thomson, Pharm.D., CACP**

**PASSING THE BATON**  
**UNITED HEALTH CARE**

“Health Services of the North East Region implemented a pilot to incorporate a Transitions of Care concept as part of a discharge planning and readmission management initiative with an eye to national implementation.

Tactics and Teams were planned and utilized, clear roles of the patients and caregivers were defined and gaining buy-in and support from our leadership, protocols were implemented, then connections were made to other providers in our community.”

**Vinnette Perry, RN, BSN, MBA**

# Helpful DEFINITIONS

## To Help You Better Understand Your Health Care

These and other helpful definitions are found on the web site here: **Guidelines for a Hospital Stay.**

Go to [www.ntocc.org](http://www.ntocc.org) to find the complete selection of NTOCC tools, including those shown at right.

**Advance Directive:**

Legal documents that allow you to convey your decisions about end-of-life care ahead of time.

**Case Manager:**

Case managers work with people to get the health care and other community services they need, when they need them, and for the best value.

**Hospitalist:**

Doctor whose primary professional focus is the general medical care of hospitalized patients. Activities include patient care, teaching, research, and leadership related to hospital medicine.

**Nurse Practitioner:**

Registered nurses who are prepared, through advanced education and clinical training, to provide a wide range of preventive and acute health care services to individuals of all ages.



**We Want to Hear From You . . .**

Visit our **FEEDBACK PORTAL** to share how you are using NTOCC tools and resources.



[Click here to give us your feedback](#)

Tell us about your models and programs and how they were developed to improve transitions.

*We look forward to hearing from you!*

**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.