

Dr. Joe V. Selby  
Executive Director  
Patient Centered Outcomes Research Institute  
1701 Pennsylvania Ave. NW, Suite 300  
Washington, DC 20006

***Re: Draft National Priorities for Research and Research Agenda***

March 12, 2012

Dear Dr. Selby:

We appreciate the opportunity to comment on the Patient Centered Outcomes Research Institute's (PCORI) *Draft National Priorities for Research and Research Agenda*. The National Transitions of Care Coalition strongly supports PCORI's mission of funding research that offers patients and family caregivers the information they need to make important health care decisions.

The National Transitions of Care 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. NTOCC members have created a number of useful tools and resources that all participants in the health care system can use to improve patient safety and decrease errors associated with poor transitions.

NTOCC submits the following recommended enhancements to the *Draft National Priorities for Research and Research Agenda*:

**Improving Healthcare Systems**

NTOCC strongly supports prioritizing research that focuses on ways to improve health care services, including the coordination of care for patients with multiple chronic conditions. However, we believe the improvement of care transitions is a vital component that should be added to this research priority area.

In the United States health and long-term care system, patients—particularly individuals with chronic illnesses and older adults—experience transitions in their care, meaning that they leave one care setting (i.e. hospital, nursing facility, assisted living facility, primary care physician care, home health care, or specialist care), and move to another. Every transition of care will

involve care coordination; however, care coordination is a related, but distinct concept that refers to the interaction of providers to ensure optimal care for a patient.

The U.S. health care system often fails to meet the needs of patients during transitions because care is rushed and responsibility is fragmented, with little communication across care settings and multiple providers. A survey by the Agency for Healthcare Research and Quality (AHRQ) on Patient Safety Culture, found that 42% of the hospitals surveyed reported that “things fall between the cracks when transferring patients from one unit to another” and “problems often occur in the exchange of information across hospital units.”<sup>i</sup> 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. All of these variables contribute to patient and family caregivers’ dissatisfaction with the U.S. health care system.

Poor transitions place significant financial burdens on patients and the U.S. health care system as a whole. In fact, the Congressional Budget Office recently identified “a focus on transitions in care settings” as one of the key components to attaining the goal of improving health care quality and reducing spending.<sup>ii</sup>

For instance, unnecessary hospital stays often result from errors and poor communication made in transitioning patients, particularly after being released from a previous hospital stay. Hospital re-admissions for the 19.6 percent of Medicare patients who must be readmitted within 30 days of their original release cost the U.S. health care system approximately \$15 billion a year. Medicare Payment Advisory Commission recently concluded that a large proportion of re-hospitalizations could be prevented with an improved discharged planning process and coordinated care after discharge.<sup>iii</sup> Medication errors harm an estimated 1.5 million people each year in the U.S., costing the nation at least \$3.5 billion annually.<sup>iv</sup> An estimated 66 percent of medication errors occur during transitions: upon admission, transfer or discharge of a patient.<sup>v</sup>

There are a number of emerging models and tools that aim to enhance patient safety, care and coordination during transitions. These models have demonstrated that effective and coordinated care transitions lead to improvements in overall health care quality, and result in savings to patients and the U.S. health care system. The Centers for Medicare and Medicaid Services (CMS) is implementing several programs, including the Community-Based Care Transitions Program, that are aimed at promoting care coordination and effective transitions. However, there remains a significant need for clinical effectiveness research that would help identify the most effective ways to empower patients to manage transitions, as well as help providers and policymakers identify, adopt and disseminate the most effective strategies to manage the care transitions process.

Given the integral aspect of care transitions in improving our health care system and the lack of current clinical effectiveness research in this area, NTOCC recommends that care transitions be clearly stated in the “Improving Healthcare Systems” on page four of the draft, to read:

*“Improving Healthcare Systems: Research should focus on 1) ways to improve access to care, receipt of care, coordination and **transitions** of care, self care, and decision making, 2) use of non-physician healthcare providers, such as nurses and physician assistants, and the impact on patient outcomes, 3) system-level changes affecting all populations, diseases, and health conditions.”*

This change should be reflected in the outline of topics within this priority research topic on page 17 of the draft document, so paragraph two states:

*“Comparative studies of health care system-level interventions, including disease management, telemonitoring, telemedicine, care management, **care transitions**, integrative health practices, care coordination, performance measurement, and quality improvement, use of incentives, protocols of treatment, clinical decision and self management support and others are lacking”*

NTOCC also believes it is important to prioritize research on “use non-physician health care providers...and the impact on patient outcomes”, but wants to reiterate that this should include nurses, physician assistants, **social workers, case managers, and pharmacists**. These providers play an integral role assisting with patient communication and information transfers. Furthermore, they can aid patients by providing support, advocacy, adherence assessment, motivational intervention, resource coordination, enhanced patient self management, and care planning.

Finally, NTOCC supports the inclusion of “examination of comparative effectiveness of changes in communication and documentation with the implementation of electronic health records” within this research priority. One of NTOCC’s key considerations for achieving successful transitions of care is the implementation of electronic health records that include standardized medication reconciliation elements. It is important that research proceeds on the most effective ways to utilize electronic health records to improve communication amongst health care providers and patient outcomes, while ensuring adequate privacy and security protections for personal health information.

### **Communication and Dissemination**

NTOCC strongly supports the emphasis on research on how to optimally communicate and facilitate the effective use of PCORI evidence by patients, family caregivers and health care professionals and the emphasis on shared decision making. It is important that research is directed at the most effective ways to empower patients and family caregivers to play an active role when a transition in their care occurs. Patients and family caregivers are often the only constants in care transitions, and few have the tools necessary to effectively navigate the fragmented health care delivery system. In many instances, family caregivers have become the de facto coordinators of care transitions, a role many are not well equipped to handle. In addition, health literacy and cultural differences between health care providers, patients, and family caregivers can further impede communication.

NTOCC strongly believes that a vital component to patient-centered care criteria should be providing patients and family caregivers with tools and resources to help make them informed consumers of care.

### **Conclusion**

NTOCC believes that with the added enhancements outlined above, PCORI's draft agenda and research priorities will help make important advancements in our health care system. We appreciate the opportunity to submit comments.

Sincerely,



Cheri Lattimer  
Executive Director

---

<sup>i</sup> "Hospital Survey on Patient Safety Culture: 2007 Comparative Database Report," Agency for Healthcare Research and Quality, 007, <<http://www.ahrq.gov/qual/hospurveydb/>>.

<sup>ii</sup> Congressional Budget Office. "Issue Brief: Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment" January 2012.

<sup>iii</sup> Medicare Payment Advisory Commission. "Report to Congress: Improving Incentives in the Medicare Program." June 2009.

<sup>iv</sup> Institute of Medicine of the National Academies. "Preventing Medication Errors: Quality Chasm Series," The National Academies Press, 2007.

<sup>v</sup> Santell, J., "Catching Medication Errors at Admission, Transfer, and Discharge," United States Pharmacopeia.