NATIONAL TRANSITIONS OF CARE COALITION

June 6, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 314-G
Washington, DC 20201

Re: Medicare Shared Savings Program: Accountable Care Organizations (CMS-1345-P)

Dear Dr. Berwick,

We appreciate the opportunity to comment on the proposed Medicare Shared Savings Program rule (CMS-1345-P). The National Transitions of Care Coalition believes that the improvement of transitions, or hand-offs, between care settings is integral to an accountable care organization's (ACO) success in providing seamless, high quality care for Medicare beneficiaries.

The National Transitions of Care Coalition (NTOCC) is a group of 32 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 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 health care can use to improve patient safety and decrease errors associated with poor transitions.

As you know, 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."[i] 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.

Furthermore, they place significant financial burdens on patients and the U.S. health care system as a whole. All of these variables contribute to patient and family caregivers' dissatisfaction with the U.S. health care system.

NTOCC strongly supports the intent of the Shared Savings Program as outlined in the proposed rule and the focus on achieving the three-part aim: better care for individuals, better health for populations and lower growth in expenditures. We are particularly supportive of the proposed rule's goal that ACOs "attend carefully to care transitions, especially as beneficiaries journey from one care system to another." However, in order to meet the needs of beneficiaries as they transition from different care settings, NTOCC submits the following recommended enhancements to the proposed rule.

Patient-Centeredness

NTOCC supports the "Patient-Centeredness Principles and Criteria" as outlined in Section II of the proposed rule. However, we feel that it is important that the final rule makes it clear that the communication process is a collaborative one that engages the beneficiary, family care-givers and the entire care team. Every episode of care involves various individuals and many times—especially for the most complex patients— multiple transfers between different care settings. It is often the non-physician members that are responsible for helping the patient navigate the different care settings. 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, adherence assessment, motivational intervention, resource coordination, enhanced patient self management, and care planning.

The current patient centeredness criteria and principles do not acknowledge the integral role these individuals have in providing patient-centered care. For instance, in regards to criteria five, current electronic health system designs focus on physician workflow without considering the needs of other care team members. It is important that the all members of the health care team—including patients and family-caregivers—have access to key pieces of information and are involved in the coordination of care in order to make the transition smooth, safe and effective.

Another area NTOCC believes could be improved is in regards to criteria number six which requires ACOs to have a "process in place for communicating clinical knowledge /evidence-based medicine to beneficiaries in a way that is understandable to them." NTOCC certainly agrees that it is important that information be communicated in a way that is understandable to patients, taking into account health literacy level which is affected by cultural and ethnic barriers in language and understanding. We appreciate the statement that this process should allow for "beneficiary engagement and shared decision making." It is important to note that shared-decision making requires collaboration with the patient. NTOCC believes in order to

facilitate this engagement ACOs will need to empower patients and family care givers to play an active role when a transition in their care occurs. Patients are the often the only constants in the transition and few have the tools to effectively navigate the fragmented health care delivery system. NTOCC strongly believes that a vital component to patient-centered care criteria should be providing patients with tools and resources to help make them informed consumers of care. At a minimum, such tools should help patients and family caregivers identify what question to ask their care team, understand who is involved in their care plan and clear time frames for steps in that care plan—such as tests and test results, follow- up appointments, and medication information.

NTOCC has developed a number of resources to empower patients and family caregivers to navigate transitions including "Taking Care of My Health Care" and "Guidelines for a Hospital Stay" which includes key questions for patients to ask their health care team during a hospital stay and items to consider after a transition. Most recently, NTOCC released the "Transitions of Care Patient Bill of Rights" which is a guide to key components of a safe and effective transition so patients and family caregivers understand what information and services they need and deserve during a transition.

Measures

NTOCC supports the care coordination and transitions quality measures included in the proposed rule; however, NTOCC urges CMS to develop, and include in future rulemakings, additional measures to promote shared accountability across care settings. Communication and transfer of information have to be complete, accurate, and as timely as possible to ensure an effective transition. 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. HIT support for this transfer of information must have the ability to document the "handover" of information and validate a receipt of acknowledgement from the receiving provider.

Secondly, NTOCC urges CMS to assess how the proposed quality measures would impact patient care preferences for those with advanced illnesses. It is not clear how the current measures would be applicable for the care provided to this population.

Conclusion

Finally, as you know, today's health care system does not emphasize communication and team work, and often medical professionals do not have the necessary training to implement the care strategies that are required to improve care coordination and transitions. These topics are not included in the curricula for most accreditation or certification programs and are infrequently among the topics of continuing medical education programs. In fact, a survey of over 1,000 physicians found that two-thirds thought they had received inadequate training in care coordination and patient education.[ii] In order for ACOs to be successful in improving transitions, medical professionals will need access to training and education to make the necessary changes that support the type of communication that is required for effective care coordination and transitions.

To that end, NTOCC's health care experts have developed a number of tools and resources for patients, family care givers and medical professionals to ensure safe transitions of care. These tools are free of charge and can be accessed through NTOCC's website www.ntocc.org. Recently, 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 "Care Transition Bundle: Seven Essential Intervention Categories" is also available which highlights the essential care transition interventions identified from a cross-walk of the various models of care. We believe these resources will be useful to entities considering participating in the Medicare Shared Savings Program.

As discussed above, the communication of timely and accurate information between providers, patients and family caregivers is critical to effective care transitions at all levels. In today's health care system information is often not available to those who need it when they need it. NTOCC supports efforts by CMS to incentivize doctors, hospitals and other health care providers to work together to better coordinate care. We feel that the suggested enhancements will help ACOs facilitate the type of communication and teamwork that is necessary to ensure safe and effective transitions.

We appreciate the opportunity to submit the above comments on ways to enhance the proposed rules governing the Medicare Shared Savings Program.

Sincerely,

Cheri Lattimer

Cheri Lattimer, Executive Director

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

[ii] Anderson, G., "Chronic Care," Advanced Studies in Medicine, 2003:3(2):110-11.