NATIONAL TRANSITIONS OF CARE COALITION

United States Senate Committee on Health Education, Labor and Pensions
Hearing on "First, Do No Harm: Improving Health Quality and Patient Safety"
May 5, 2011
Statement for the Record
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Chairman Harkin and Ranking Member Enzi 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 strongly 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 group of 32 leading health care experts 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.

In the United States health and long-term care system, patients—particularly the elderly and individuals with chronic illnesses— 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. 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.

Some key facts about transitions of care:

- Among hospitalized patients 65 or older, 21 percent are discharged to a long term care or other institution.[i]
- Approximately 25 percent of Medicare skilled nursing facility (SNF) residents are readmitted to the hospital.[ii]

- Individuals with chronic conditions—a number expected to reach 125 million in the U.S. by 2020—may see up to 16 physicians in one year.[iii]
- Between 41.9 and 70 percent of Medicare patients admitted to the hospital for care in 2003 received services from an average of 10 or more physicians during their stay.[iv]

A recent 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."[v] 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.

We need only to look at the high prevalence of hospital readmissions and medical errors to see the inadequacies of care transitions and their adverse economic implications to the U.S. health care system:

- Medication errors harm an estimated 1.5 million people each year in the United States, costing the nation at least $3.5 billion annually.[vi] An estimated 66 percent of medication errors occur during transitions: upon admission, transfer or discharge of a patient.[vii]
- One study found that, on discharge from the hospital, 30% of patients have at least one medication discrepancy.[viii]
- According to another study, one in five U.S. patients discharged to their home from the hospital experienced an adverse event within three weeks of discharge. Sixty percent were medication related and could have been avoided.[ix]
- On average, 19.6% of Medicare fee-for-service beneficiaries who have been discharged from the hospital were readmitted within 30 days and 34% were readmitted within 90 days.[x] According to MEDPAC, hospital readmissions within 30 days accounted for $15 billion of Medicare spending.[xi]

NTOCC's health care experts have developed a number of tools and resources for professionals and policymakers to ensure safe transitions of care. These include resources to: help patients and family caregivers navigate transitions; assist health care professionals in implementing and evaluating effective transitions of care plans; and aid policymakers in assessing and measuring transitions of care outcomes.

There are a number of models of care that have demonstrated that effective and coordinated care transitions lead to improvements in overall health care quality, and results in savings to patients and the health care system. Each model brings a set of interventions, tools, and

resources that help to address the issues of communication, transfer of patient information, accountability for sending and receiving information and improving quality of care. To assist medical providers, NTOCC recently 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 this resource will be useful as this Committee and the Administration look to improve health care quality and safety.

In recognition of the value of proper transitions in leading to improved care and the social and economic costs of poor transitions, the Patient Protection and Affordable Care Act included several initiatives specifically designed to address gaps in care that occur between and among health care settings. NTOCC is particularly supportive of the Health and Human Services (HHS) recently announced "Partnership for Patients" which identifies effective care transitions as a key component of improving the quality, safety, and affordability of health care for all Americans. As part of this initiative, CMS announced the Community-based Care Transitions Program (CCTP) which was created by the Affordable Care Act and will provide $500 million to eligible community based organizations and acute care hospitals for care transition services for high risk Medicare beneficiaries. NTOCC strongly supports the CCTP program and urges Congress to continue to support this important program.

Finally, as new policies and programs emerge that seek to improve care transitions, NTOCC believes the following considerations should be taken into account to achieve successful transitions of care:

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

The National Transitions of Care Coalition appreciates the opportunity to submit a statement for the record and looks forward to working with the Committee to health care quality and patient safety.

[i] "Hospitalization in the United States, 2002," Agency for Healthcare Research and Quality, 2002 .<http://www.ahrq.gov/data/hcup/factbk6/factbk6a.htm#howdischarged>.

[ii] Medicare Payment Advisory Commission, "Report to the Congress: Increasing the Value of Medicare," June 2006.

[iii] Bodenheimer, T, "Coordinationg Care-a perilous journey through the health system," New England Journal of Medicine, 2008; 358(10):1064-1071.

[iv] Fisher, E, "Performance, Measurement: Achieving Accountability for Quality and Costs," Quality Forum Annual Conference on Health Policy, October 2006.

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

[vi] Harris, G, "Report Finds a Heavy Toll from Medication Errors," *New York Times*, 21 July 2006 .

[vii] Santell, J., "Catching Medication Errors at Admission, Transfer and Discharge," United States Pharmacopia

[viii] Kwan, Y, Fernandes, OA, , JJ et al., "Pharmacist medication assessments in a surgical preadmission clinic," Arch Intern Med, 2007;167:1034-40.

[ix] Forester, AJ, Murff, HJ, Peterson, JF, et al., "The incidence and severity of adverse events affecting patients after discharge from the hospital," Annals of Internal Medicine, 2003:138(3):161-7.

[x] Jencks, Stephen F, Williams, Mark V, Coleman, Eric A, "Rehospitilizations among Patients in the Medicare Fee for Service Program," New England Journal of Medicine, 2 Apr 2009;360:1418-1428.

[xi] Medicare Payment Advisory Commission, "Report to Congress: Promoting Greater Efficiency in Medicare," June 2007, Chapter 5.