The State of Transitions of Care:
Findings from the 2025 NTOCC National Summit

A National Report from the National Transitions of Care Coalition

March 2026

Executive Summary

In September 2025, the National Transitions of Care Coalition (NTOCC) convened a national Working Summit to examine the ongoing challenges affecting transitions of care across the healthcare continuum. Eighty healthcare professionals representing hospitals, post-acute providers, pharmacists, case managers, policy leaders, and care coordination experts from across the country gathered to identify the most pressing barriers, emerging opportunities, and strategic priorities for improving care transitions nationwide. During the Summit, these participants were engaged with live polling, digital response tools, and open discussion to capture real-time insights from professionals working directly within transition processes.

Despite decades of progress in healthcare quality improvement, summit participants consistently described the current state of transitions of care as fragmented, disconnected, and inconsistent across care settings. These systemic gaps continue to place patients—particularly those with chronic illness, behavioral health conditions, or complex care needs—at risk during critical handoff moments between providers.

Participants identified several persistent barriers, including inadequate reimbursement structures, limited interoperability between healthcare systems, incomplete discharge communication, and unclear accountability across care settings. At the same time, participants highlighted significant opportunities to strengthen transitions through improved technology integration, expanded roles for pharmacists and care coordination professionals, and standardized discharge communication protocols.

Importantly, summit participants emphasized that improving transitions of care requires coordinated policy and practice reforms. Participants called for national discharge communication standards, modernization of reimbursement models that support care coordination, and greater alignment between healthcare systems, payers, and policymakers.

The findings presented in this report reflect the collective insights gathered through live polling, written responses, and facilitated discussions during the Summit. These insights will guide NTOCC's strategic priorities for 2026 and inform ongoing national conversations about how healthcare systems can better protect patients during one of the most vulnerable points in their care journey.

Introduction: Why the Summit Was Convened

Transitions of care represent one of the most vulnerable moments in the healthcare system. When patients move between care settings—such as from hospital to home, hospital to skilled nursing facility, or emergency department to outpatient care—the responsibility for treatment, communication, and follow-up shifts between clinicians and organizations.

When these handoffs fail, the consequences can be severe. Poorly coordinated transitions are associated with medication errors, missed follow-up care, avoidable hospital readmissions, increased healthcare costs, and negative patient outcomes.

Recognizing the continued need for improvement, the National Transitions of Care Coalition convened the 2025 Transitions of Care Working Summit to bring together leaders from across the healthcare continuum to examine current realities, identify barriers, and explore solutions for strengthening care transitions nationwide.

The Summit was designed as an interactive working session rather than a traditional conference. Participants engaged in live polling, digital response tools, and open discussion to capture real-time insights from professionals working directly within transition processes.

Key Findings from the Summit

1. Current Reality of Transitions of Care

Participants consistently described the current state of care transitions using the following terms:

- Fragmented
- Disconnected
- Disorganized
- Siloed
- Chaotic

These descriptions align with national research showing that despite technological advances and policy efforts, transitions of care remain inconsistent across healthcare systems.

Participants emphasized that while individual organizations may have implemented successful programs, the lack of standardized expectations across the healthcare ecosystem continues to create variability and risk.

Without greater structure, accountability, and communication standards, patients remain vulnerable during the most critical handoff points in the healthcare system.

2. Barriers Identified by Participants
Participants identified several systemic barriers that continue to undermine effective care transitions:

a. **Limited Reimbursement Support**

   Care coordination activities—including communication between providers, medication reconciliation, and patient education—are often inadequately reimbursed within current payment models

b. **Difficulty Reaching the Correct Point of Contact**

   Providers frequently struggle to identify the appropriate individual responsible for receiving or providing critical information during transitions.

c. **Lack of Shared Accountability**

   Responsibility for successful transitions is often unclear across care settings, resulting in fragmented ownership of patient outcomes.

d. **Incomplete Discharge Information**

   Participants reported that discharge summaries are frequently delayed, incomplete, or inaccessible to receiving providers.

e. **Interoperability Challenges**

   Healthcare professionals continue to rely on manual workarounds due to limited interoperability between electronic health record systems.Participants emphasized that these barriers reflect systemic gaps rather than isolated institutional failures.

f. **Opportunities for Progress**

   While challenges remain significant, participants also identified several promising opportunities to strengthen transitions of care.

3. Technology and AI-Supported Communication

Participants highlighted the potential for technology to support more efficient handover communication, particularly through AI-supported discharge summaries and improved clinical documentation tools.However, participants emphasized that technology must support—not replace—human clinical oversight.

4. Strengthening the Role of Pharmacists and Care Coordinators
Participants consistently emphasized the critical role pharmacists and case managers play in medication reconciliation, patient education, and care coordination.
Expanding their role in transition planning could significantly improve patient safety and reduce avoidable complications.

5. Standardized Patient-Centered Communication
Participants supported the development of standardized discharge communication practices that ensure patients and family caregivers understand their care plan, medications, and follow-up requirements.

6. Policy Expectations
Participants emphasized that meaningful improvements in transitions of care will require policy changes alongside practice improvements.
Key policy priorities identified during the Summit include:

- Establishing national discharge communication standards
- Modernizing reimbursement models to support care coordination
- Defining clearer role ownership across care settings
- Reducing administrative burdens that limit time for patient engagement
- Recognizing pharmacists as providers of care within billing frameworks

Participants emphasized that policy reform must support coordinated, team-based approaches to care transitions.

7. Role Expectations for NTOCC
Summit participants consistently identified NTOCC as playing several critical roles in advancing transitions of care nationwide.
Participants described NTOCC as:

- A voice that elevates patient safety above institutional convenience
- A standards-setting organization
- A policy advocate
- A trusted convener for cross-sector collaboration
- An educator supporting healthcare professionals across care settings

These expectations reflect the organization's longstanding role in advancing awareness and collaboration around care transitions.

Strategic Direction for 2026
Based on Summit findings, several strategic priorities emerged to guide NTOCC's work in the coming year.

a. **Measurement and Accountability** Develop simple, standardized indicators that allow healthcare organizations to measure and track transition quality.
b. **Policy Reform** Advocate for federal and payer alignment on discharge communication expectations, reimbursement modernization, and expanded pharmacist roles.
c. **Technology and AI Standards** Develop guidance on how technology and artificial intelligence should be used to support safe transitions of care.
d. **Education and Workforce Support** Equip healthcare professionals with practical tools, templates, and shared language that facilitate effective cross-setting collaboration.

Closing Summary

The findings from the 2025 NTOCC Summit reflect broad consensus among healthcare professionals working across the care continuum: transitions of care remain one of the most vulnerable points within the healthcare system.

Participants emphasized that improving care transitions is no longer a matter of debating whether change is needed. The focus has shifted to how rapidly healthcare systems can implement consistent, standardized approaches to protect patients during these critical handoffs.

Participants also emphasized the need for transition frameworks that ensure high-risk patients receive timely follow-up care and that communication between clinicians occurs before those visits take place.

As healthcare systems continue to move toward value-based reimbursement models, responsibility for patient outcomes increasingly extends beyond individual care encounters. Hospitals, post-acute providers, clinicians, and care coordinators must work together to ensure transitions are dependable, safe, and patient-centered.

The message from the Summit was clear: **ToC is A Shared Responsibility**

Improving transitions of care requires intentional teamwork, shared accountability, and stronger communication across the healthcare continuum.

As one participant summarized during the Summit discussions:
“Pass the baton—don’t throw it.”

About the National Transitions of Care Coalition

The National Transitions of Care Coalition (NTOCC) is a multidisciplinary coalition dedicated to improving patient safety and care coordination during transitions between healthcare settings. Through research, policy engagement, education, and collaboration across the healthcare continuum, NTOCC has worked to advance national awareness and implementation of safe transitions of care practices. NTOCC developed the widely recognized Seven Essential Elements of Successful Transitions of Care and the Care Transitions Bundle, which have been adopted by healthcare organizations, educational institutions, and quality improvement initiatives nationwide.

Appendix A:

Summit Agenda and Speakers

Summit Opening & Welcome Introduction of the NTOCC National Board ……	Jackie Vance, NTOCC President
Opening Keynote: The Future of Transitions of Care…….	Shari Ling, MD, CMS Deputy Chief Medical Officer
Bridging Gaps Between Acute & Post-Acute Care……	Christian, Bergman, MD, CMD, Virginia Commonwealth University Jackie Vance, RNC, BSN,CDONA/LTC, FACDONA, IP-BC, CDP, LBBP, DPN – Mission Health
Building Standards for Transitions of Care……	Terrence O'Malley, MD.,CMD Corresponding Faculty Harvard Medical School
The Future of Value Based Care……	Stephen Buslovich, MD,CMD,MS Chief Medical Officer, Senior Care Tom Haithcoat, President, Ceptor Consulting, LLC
Policy Updates: The Impact of Transitions of Care…..	Alex Bardakh, MPP, CAE, PALTC
Pharmacists & Their Impact on Transitions of Care….	Sara Panella, PharmD, CPh, BCPS, FASHP Emory Health South Florida Chad Worz, PharmD, BCGP CEO -ASCP
Case Study Presentations Innovative Models for Successful Care Transitions……	Norris Turner, PharmD, PhD, Turner Consulting Cheri Lattimer, RN, BSN, Executive Director, NTOCC Trisha Cash, PharmD, BCGP, CDCES, Fredrick Integrated Health Networks Diane Kittle, MSN, RN, CCM, Complex Care Transitions Team Mayo,AZ Saswat Kabisatpathy, PharmD, CSO, Avant Pharmacy & Wellness Center
Moderator, Speakers & Attendees Discussions…… Roadmap to Closing the Gaps	Norris Turner, PharmD, PhD

Appendix B:
Summit Polling and Discussion Questions

During the 2025 NTOCC Transitions of Care Working Summit, participants engaged in structured polling and discussion designed to capture real-world perspectives from professionals working across the care continuum. The following questions guided participant reflection, polling responses, and collaborative dialogue.

Section 1: Current State of Transitions of Care

1. What's one word that describes your organization's transitions of care today?
2. What's your biggest barrier to smoother handoffs?
3. What's one goal you want to walk away with from today's Summit?
4. Who are the members of your transitions of care team?
5. Note one challenge highlighted by Dr. Shari Ling that directly resonates with your work.
6. Where is the biggest opportunity for immediate innovation in your setting?
7. What additional barriers do you identify as clear breakdowns in providing safe and quality transitions?

Section 2: Communication and Discharge Processes

8. Are there other areas or content that should be added to a well-written discharge summary?
9. Is there anything more required of communication at a transition of care beyond being complete, timely, usable, and requiring little effort to produce or use?
10. In addition to the sending team, receiving team, and the patient and caregivers, are there other essential participants involved in safe transitions?

Section 3: Technology and Artificial Intelligence

11. How do you see artificial intelligence supporting a safe and high-quality transition of care for providers, patients, and their identified family caregivers?
12. How could standards combined with technology accelerate progress in your organization?
13. What role should technology and real-time data sharing play in making transitions smoother across hospitals, skilled nursing facilities, home health agencies, and primary care?
14. What barriers still stand in the way of effective data sharing and interoperability?

Section 4: Measurement and Standards

15. If quality measurement for transitions of care is phased in nationally, what are the most important elements to start with?
16. What standards would help accelerate progress in transitions of care within your organization?
17. What information should be consistently included in discharge summaries to improve transition quality?

Section 5: Policy and Payment Reform

18. If you could change one policy or practice tomorrow, what would it be?
19. What new policy or regulation could impact your role in transitions of care?
20. As value-based payment models evolve, how should financial incentives and accountability be aligned across providers to ensure responsibility for care transitions is shared across the continuum?
21. How can value-based models ensure transitions prioritize patient-centered outcomes such as quality of life, functional status, and caregiver satisfaction?
22. What do you believe is missing from the current transitions of care landscape?
23. Which advocacy actions should NTOCC prioritize in order to advance safe and effective transitions of care?

Section 6: Pharmacy and Medication Management

24. What pharmacy-based intervention discussed today struck you as most scalable?
25. How could this intervention be adapted to your organization or care setting?
26. What areas in your work environment could pharmacists support transitions of care and care coordination?
27. What role do pharmacists currently have in your discharge or transition processes?

Section 7: Team Collaboration and Workforce

28. Collaboration among all care team members is crucial. How would you rate collaboration among your care team?
    Options included:
    - None
    - Very Little
    - Currently Developing
    - Working Well Among All Disciplines
29. How are case managers and social workers utilized within your transitions of care programs?
30. How will improved collaboration among care team members impact the care delivery model?

Section 8: Innovation and Future Care Models

31. What aspects of the GUIDE model could benefit future care delivery models with an emphasis on transitions of care?
32. What priorities should be included on a shared national roadmap for improving transitions of care?
33. If we don't fix _____, the system will continue to fail patients.

Section 9: Reflection and Commitment

34. What is the most valuable insight you are taking home from today's Summit?
35. Who will you share today's insights with?
36. What are the top three actions you will pursue following this Summit?
37. What support do you need from NTOCC to make progress?
38. What one step will you commit to taking within the next 30 days?

This appendix documents the structured dialogue used to capture participant insights that informed the findings presented in this white paper.

Appendix C
Summit Participant Poll Results

The following results summarize responses gathered from live polling and written feedback during the 2025 NTOCC Transitions of Care Working Summit. Responses reflect the perspectives of healthcare professionals from across the country working in hospitals, post-acute providers, pharmacy services, care management programs, and payer organizations.

1. Current State of Transitions of Care
Participants were asked to describe the current state of transitions of care within their organizations using one word.

Most Common Responses
Participants most frequently described transitions of care as:

- Fragmented
- Siloed
- Disjointed
- Disparate
- Chaotic
- Complicated

Other responses included:

- Evolving
- Transforming
- Innovative
- In Process
- Growing
- Compliant

These responses indicate that while some organizations report progress, the dominant perception remains that transitions of care lack consistency and structure across the healthcare system.

2. Biggest Barriers to Smoother Handoffs
Participants identified several major barriers to safe transitions:
Communication Challenges

- Difficulty reaching the correct individuals
- Communication breakdowns between providers
- Barriers between payers, providers, community organizations, and caregivers

Technology Limitations

- Lack of full electronic health record integration
- Limited interoperability between systems

Operational Challenges

- Duplicate efforts across teams
- Lack of actionable transition data
- Limited incentives for providers to prioritize care coordination

Participants emphasized that smoother transitions require stronger communication pathways and better system integration.

3. Goals Participants Wanted to Achieve at the Summit

Participants expressed interest in several key outcomes:

- Learning strategies used successfully by other healthcare organizations
- Developing new professional connections and collaboration opportunities
- Identifying next steps for improving care coordination
- Demonstrating the value of interdisciplinary care teams
- Advancing value-based care approaches to transitions

These responses reflect strong interest in collaborative learning and practical implementation strategies.

4. Members of Transitions of Care Teams

Participants identified a wide range of professionals involved in transitions of care, including:

- Physicians
- Nurses
- Nurse navigators
- Pharmacists
- Social workers
- Case managers
- Community health workers
- Care coordinators
- Discharge planners
- Community service providers
- Payers
- Patient caregivers

These responses highlight the interdisciplinary nature of effective transitions of care.

5. Key Challenges Highlighted During the Summit

Participants identified several systemic challenges raised during the keynote discussion:

- Lack of standardized data reporting
- Complex regulatory and reporting requirements
- Limited workforce capacity
- Difficulty connecting providers and healthcare entities
- Lack of outcome-specific care plans

These challenges reinforce the need for clearer standards and coordination across organizations.

6. Opportunities for Immediate Innovation

Participants identified several areas where innovation could improve transitions of care:

- Improving interoperability across healthcare systems
- Implementing visible advanced care planning across care settings
- Empowering pharmacists and paramedics to provide frontline care
- Developing interdisciplinary working groups focused on transitions
- Improving collaboration between providers and payers
- Securing leadership support for care transition initiatives

Interoperability and interdisciplinary collaboration were the most frequently mentioned opportunities.

7. Additional Barriers to Safe Transitions

Participants also identified additional breakdowns that contribute to unsafe transitions:

- Lack of clear ownership of the transition process
- Workforce workload and staffing pressures
- Insufficient staff training and experience
- Limited attention to social determinants of health
- Lack of accountability for transition outcomes

8. Improvements Needed in Discharge Summaries

Participants identified several elements that should be included in stronger discharge documentation:

- Clear identification of held or discontinued medications
- A forward-looking section explaining “what happens next”
- Baseline patient understanding of disease and medications
- Confirmation that patients understand their discharge plan
- Accurate prognosis information
- Advance care planning information (POLST, code status)
- Primary caregiver identification
- Case management plan
- Long-term care planning considerations
- Social determinants of health outcomes
- Documentation of patient priorities and goals of care

Participants emphasized that discharge summaries should support both clinical teams and patients.

9. Role of Artificial Intelligence in Transitions of Care
Participants identified several potential applications for AI:

- Generating patient-friendly discharge instructions
- Summarizing complex clinical records
- Identifying readmission risk
- Producing tailored documentation for clinicians and caregivers
- Providing real-time access to patient care plans

Participants emphasized that AI should operate **with human oversight** to maintain patient safety.

10. Essential Participants in Transitions of Care

In addition to sending and receiving providers, participants identified several additional critical stakeholders:

- Outpatient pharmacies
- Primary care providers
- Payers
- Community service organizations

These participants play key roles in ensuring continuity of care after discharge.

11. Measurement and Standards
Participants emphasized the importance of developing measurable transition standards, including:

- Ability to submit supplemental clinical information beyond claims data
- Timely exchange of discharge summaries
- Standardized information formats
- Real-time data access across care settings

Participants indicated that stronger standards could significantly improve transition reliability.

12. Policy Changes Participants Would Prioritize

Participants identified several policy priorities:

- Reimbursement for pharmacist services in transitions of care
- Elimination or reform of prior authorization requirements
- Telehealth policy permanence
- Medication reconciliation requirements during transitions
- Required social determinants of health documentation
  Expanded provider status for pharmacists

Pharmacist provider status emerged as a recurring theme across responses.

13. Technology and Data Sharing
Participants emphasized the importance of real-time data exchange across care settings.
Key barriers identified included:

- Lack of interoperability between EHR systems
- Organizational bureaucracy limiting technology adoption
- Inaccurate perceptions of HIPAA restrictions
- Limited data availability beyond specific patient panels

Participants emphasized that technology must support clinical workflows rather than increase administrative burden.

14. Value-Based Care Alignment
Participants emphasized that financial incentives must align across care settings.
Suggested approaches included:

- Shared payment models tied to collaboration across providers
- Incentives for successful care transitions
- Payment structures supporting medication reconciliation
- Shared accountability between hospitals, primary care, and specialists

Participants noted that current mixed fee-for-service and value-based environments create conflicting incentives.

15. Pharmacy's Role in Transitions
Participants emphasized the importance of pharmacists in transitions of care, particularly in:

- Medication reconciliation
- Patient medication education
- Insurance and medication affordability support
- Coordination with outpatient pharmacies
- Medication optimization

However, many participants reported that pharmacists are currently underutilized in discharge processes.

16. Collaboration Across Care Teams
Participants reported high levels of collaboration across disciplines.
Collaboration Rating
Working well among disciplines: **92%**
Participants emphasized that multidisciplinary collaboration improves care planning and reduces duplication of effort.

17. Role of Case Managers and Social Workers
Participants described case managers and social workers as central drivers of transitions of care programs.
Their roles include:

- Discharge planning
- Post-discharge follow-up
- Coordination with providers and community resources
- Addressing social determinants of health
- Supporting patient and caregiver communication

18. Key Themes for Future Care Models
Participants identified several elements that could shape future transition models:

- Telehealth integration
- Bundled payment models
- Greater focus on social determinants of health
- Expanded local care delivery models
- Increased collaboration across disciplines

19. Priority Areas for a National Roadmap
Participants identified several priorities for improving transitions of care:

- Collaborative practice models
- Stronger community resource integration
- Increased access to care
- Shared performance indicators
- Reimbursement reform

20. Reflection and Commitments
Participants highlighted several key takeaways:

- The importance of advocacy for reimbursement reform
- The need for stronger collaboration across care settings
- The value of asking difficult questions about system gaps
- The importance of sharing insights with leadership teams

Many participants expressed commitment to continuing advocacy and collaboration efforts following the Summit.

Closing Insight from Participants

One message that resonated throughout the Summit discussions was captured in a phrase shared by multiple participants: **“Pass the baton — don’t throw it.”**

This statement reflects the core principle of safe transitions of care: responsibility must move intentionally between providers to protect patients during vulnerable handoffs.

Note: Because the polling data was collected using a **mixed-response format**, not every question generated the same type or volume of answer set.

The number of questions does not match the number of answers because the Summit used **multiple polling formats**, including word clouds, open-text responses, and at least one multiple-choice question. In that format, not every participant answered every question, some participants may have skipped questions, and some questions produced many short entries while others produced only a handful of detailed responses. In addition, several questions were designed for live discussion or reflection and may not have produced a full exported response set in the polling report.