NATIONAL TRANSITIONS OF CARE COALITION

Improving Transitions of Care

The National Transitions of Care Coalition (NTOCC) is a coalition of 30 diverse organizations dedicated to providing solutions that improve the quality of health care with better collaboration between providers, patients, and caregivers. The term "transitions of care" connotes the scenario of a patient leaving one care setting (i.e., hospital, nursing facility, assisted living facility, primary care physician care, home health care, or specialist care) and moving to another.

In the U.S. health and long-term care system, many patients experience transitions of care.

- 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.[1]
- Among hospitalized patients 65 or older, **23 percent are discharged to another institution**, and nearly **12 percent receive home health care**.[2]
- On average, patients 65 or older with two or more chronic conditions see seven different physicians within one year, accounting for **95 percent of Medicare expenditures**.[3]

Miscommunication during transitions of care can reduce the quality of care significantly, leading to:

- Medication errors, both overuse and sub-optimal use of prescription drugs **harm an estimated 1.5 million people** each year in the United States, costing the nation at least **$3.5 billion annually**;[4]
- Patient and caregiver **confusion** about patient's condition and appropriate care;
- **Lack of follow-through** on referrals; and
- Increased costs because missing test results, discharge summaries, referrals, and medication lists may require patients to schedule **redundant appointments** or may lead providers to prescribe **duplicative medications**.

NTOCC believes the following considerations are important to better transitions of care:

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

Learn more at www.NTOCC.org.

---

[1] E Fisher, *Performance Measurement: Achieving Accountability for Quality and Costs.* Paper presented at the 2006 Quality Forum Annual Conference on Health and Policy, Washington, DC (Oct. 2006).

[2] Agency for Healthcare Research and Quality (AHRQ), *Outcomes by Patient and Hospital Characteristics for All Discharges* (1999).

[3] JL Wolff et al., *Prevalence, Expenditures, and Complications of Multiple Chronic Conditions in the Elderly*, Archives of Internal Med. 162: 2269-76 (2002).

[4] G Harris, *Report Finds a Heavy Toll From Medication Errors,* N.Y.TIMES (July 21, 2006) *available at* http://www.nytimes.com/2006/07/21/health/21drugerrors.html?ex=1189828800&en=be8e73b215716d8d&ei=5070.