VERMONT MEDICAL SOCIETY RESOLUTION

Improving Transition of Care

Adopted October 19, 2013

Whereas, the U.S. health care system often fails to meet the needs of patients transitioning from one care setting to another (i.e., hospital, home or a long-term care facility), and care is frequently rushed, responsibility is fragmented, and there is often little communication between care settings and multiple clinicians. The ensuing confusion regarding a patient's condition or needs, can cause inconsistent patient monitoring, duplicative tests, medication errors, delays in diagnosis, and lack of follow through on referrals; and

Whereas, ineffective hand-off communication is recognized as a critical patient safety problem in health care. The "hand-off" process involves "senders," the clinicians transmitting patient information and releasing the care of that patient to the next clinician, and "receivers," the clinicians who accept the patient information and care of that patient.

Whereas, problems resulting from poor transitions can lead to significant financial burdens for patients, payers and the U.S. health care system as a whole - for example, unnecessary hospitals stays often result from errors and poor communication made in transitioning patients, particularly after being released from a previous hospital stay, and

Whereas, 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; and

Whereas, the Medicare Payment Advisory Commission recently concluded that a large proportion of re-hospitalizations could be prevented with an improved discharge planning process and coordinated care after discharge; and

Whereas, medication errors are reported to harm an estimated 1.5 million people each year in the U.S., costing the nation at least $3.5 billion annually. An estimated 66 percent of medication errors occur during transitions: upon admission, transfer or discharge of a patient; and

Whereas, the National Transitions of Care Coalition has developed a bundle of 7 essential care-transition intervention strategies that any clinician interested in implementing improvements in care transition can consider for use:

1. **Medications Management** – Ensuring the safe use of medications by patients and their families and based on patient's plans of care;
2. **Transition Planning** – A formal process that facilitates the safe transition of patients from one level of care to another including home or from one practitioner to another;
3. **Patient and Family Engagement/Education** – Education and counseling of patients and families to enhance their active participation in their own care including informed decision making;

4. **Information Transfer** – Sharing of important care information among patient, family caregiver and healthcare providers in a timely and effective manner;
5. **Follow-up Care** – Facilitating the safe transition of patients from one level of care or provider to another through effective follow-up activities;
6. **Healthcare Provider Engagement** – Demonstrating ownership, responsibility and accountability for the care of the patient and family/caregiver at all times;
7. **Shared Accountability across Providers and Organizations** – Enhancing the transition of care process through accountability for care of the patient by both the healthcare provider (or organization) transitioning and the one receiving the patient.

Whereas, The primary driver in creating two new CPT Transitional Care Management (TCM) codes has been to improve care coordination and to provide better incentives to ensure patients are seen in a physician's office, rather than be at risk for readmission; now therefore be it

Resolved, that VMS work with the physician community, and payors to educate on the use of the transition of care codes 99495 and 99496 to improve care coordination and to provide better incentives to ensure that patients are communicated with and seen in a physician's office in a timely manner, rather than be at increased risk for readmission; and be it further

Resolved, that VMS work with Vermont Association of Hospitals and Health Systems and the entire hospital community to enhance and encourage proper communication of precise, timely, and meaningful discharge summaries.