

**NHPF Forum Session**  
Meeting Announcement

**NATIONAL  
HEALTH  
POLICY  
FORUM**

**Lost in Transition: Challenges and Opportunities in Moving Patients Between Health Care Settings**

**A DISCUSSION FEATURING:**

**Robert Berenson, MD**  
*Senior Fellow*  
The Urban Institute

**Eric A. Coleman, MD, MPH**  
*Associate Professor of Medicine*  
Divisions of Geriatric  
Medicine and Health Care  
Policy and Research  
University of Colorado Health  
Sciences Center

**Carol Raphael**  
*President and Chief Executive Officer*  
Visiting Nurse Service of  
New York

**Thursday,  
October 7, 2004**

11:45 am — *Lunch*

12:15–2:00 pm — *Discussion*

**Reserve Officers Association  
of the United States**

One Constitution Avenue, NE  
Congressional Hall of Honor —  
Fifth Floor  
(Across from the Dirksen Senate  
Office Building)

**To register:**

Please call Tiombé Diggs at  
202/872-1392 as soon as  
possible. Space is limited.

**For additional  
information on this topic:**

See “Lost in Transition: Chal-  
lenges and Opportunities for  
Improving the Quality of  
Transitional Care” by Drs.  
Coleman and Berenson [*Ann.*  
*Intern. Med.*, Oct. 7, 2004: 140].

THE GEORGE  
WASHINGTON  
UNIVERSITY  
WASHINGTON DC

## Lost in Transition: Challenges and Opportunities in Moving Patients Between Health Care Settings

As patients face medical problems, they may repeatedly have to move in and out of hospitals (or even from one part of a hospital to another), to private homes, skilled nursing facilities (SNFs), and rehabilitation centers. Many of these transitions are unplanned, unanticipated, and occur in “real time”—even after business hours, including nights and on weekends. An expanding evidence base suggests these transitions account for a significant portion of medical errors, service duplication, and unnecessary utilization.<sup>1</sup>

Building on an article by Drs. Eric Coleman and Robert Berenson and following up on issues that arose during a National Health Policy Forum site visit to New York City, this meeting will explore the difficulties inherent in moving patients among different health care settings. During these transitions, patients often encounter multiple payment systems and providers, each of which has varying incentives and standards of care. Moving patients in and out of institutional and home-based settings and sometimes back again often causes tremendous adjustment problems for patients, particularly older adults who may be frail, suffer from dementia, or lack caregivers.<sup>2</sup> Quantitative evidence has shown that patient safety is jeopardized during transitions in care. Medication errors, as patients move between prescribers, pose a particularly significant threat.

The challenges to improving quality of transitional care occur at multiple levels and include the following factors: patients, practitioners, health care institutions, information technology, payment, and regulatory oversight. The authors argue that, even when used, care management and disease management approaches often do not

### SESSION OVERVIEW

This meeting will explore the difficulties inherent in moving patients between health care settings (for example, from their home to a hospital, to a skilled nursing facility, and back home again). It will also consider potential solutions for improving the quality of transitional care.

#### Forum Session Manager

**Nora Super**

*Principal Research Associate*

#### National Health Policy Forum

2131 K Street NW, Suite 500

Washington DC 20037

202/872-1390

202/862-9837 [fax]

nHPF@gwu.edu [e-mail]

www.nHPF.org [web]

**Judith Miller Jones**

*Director*

**Sally Coberly**

*Deputy Director*

**Monique Martineau**

*Publications Director*

NHPF is a nonpartisan education and information exchange for federal health policymakers.

specifically address the problems intrinsic to providing transitional care. This meeting will explore potential solutions for improving the quality of transitional care.

## KEY QUESTIONS

This interactive Forum session will allow speakers and audience members to share clinical, policy, and personal experiences about the inherent challenges in transitional care. The discussion will center around the following key questions:

- To what extent does transitional care require its own agenda and unique set of strategies to address the multiple and complex factors that affect both quality and outcomes?
- Do health care practitioners have the ability to respond to these issues on their own? What barriers exist?
- What payment policies might promote high-quality transitional care?
- Do beneficiaries who are dually eligible for both Medicare and Medicaid and typically use more health care services experience special challenges in navigating transitions in care?
- What role can care coordination play in improving transitions? What are its limitations?
- Can accreditation and performance measurement entities such as the Joint Commission on Accreditation of Healthcare Organizations, the National Quality Forum, or the National Committee for Quality Assurance help improve transitional care?

## SPEAKERS

**Robert Berenson, MD**, is a senior fellow at the Urban Institute. He is an expert in health care policy, particularly Medicare, with experience practicing medicine, serving in senior positions in two presidential administrations, and helping organize and manage a successful preferred provider organization. From 1998 to 2000, Dr. Berenson was in charge of Medicare payment policy and managed care contracting in the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services).

**Eric A. Coleman, MD, MPH**, is associate professor of medicine within the division of health care policy and research and geriatric medicine at the University of Colorado Health Sciences Center. As a board-certified geriatrician, Dr. Coleman maintains direct patient care responsibility for older adults in ambulatory, acute, and sub-acute care settings. Dr. Coleman's research focuses on: enhancing the role of patients and caregivers in improving the quality of their care transitions across acute and post-acute settings, developing

performance measures to assess the quality of care transitions, and implementing system-level practice improvement interventions.

**Carol Raphael** is president and chief executive officer of the Visiting Nurse Service of New York, the country's largest voluntary home health care organization. The organization provides a wide range of acute, rehabilitative, and long-term care services and operates a health plan and research center. Previously, Ms. Raphael held positions as director of operations management at Mt. Sinai Medical Center and executive deputy commissioner of the Human Resources Administration in charge of the Medicaid and Public Assistance programs in New York City. Ms. Raphael is a member of the Medicare Payment Advisory Commission, which advises Congress on Medicare payments and policies.

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## ENDNOTES

1. Eric A. Coleman and Robert A. Berenson, "Lost in Transition: Challenges and Opportunities for Improving the Quality of Transitional Care," *Ann. Intern. Med.* (forthcoming, October 7, 2004): 140.
2. Lisa Sprague and Nora Super, "Transitions along the Continuum of Care: Elderly and Disabled Persons in New York," Site Visit Report, National Health Policy Forum, March 4–5, 2002; available at [www.nhpf.org/pdfs\\_sv/SV\\_NYC02.pdf](http://www.nhpf.org/pdfs_sv/SV_NYC02.pdf).