## James L. Holly, M. D.

#### Physician Consortium for Performance Improvement Care Transition Data Set Tutorial for Using SETMA's Deployment

#### 2009 Introduction to SETMA's Care Transition Tutorial

In June, 2009, the Physician Consortium for Performance Improvement, which in part includes the American Board of Internal Medicine Foundation, American College of Physicians, Society of Hospital Medicine and the AMA Physician Consortium, published Care Transitions: Performance Measurement Set entitled Phase I: Inpatient Discharges and Emergency Department Discharges.

Since 2003, SETMA has utilized NextGen EMR in the in-patient setting in order to complete Admission History and Physician examinations and Discharge Summaries (renamed Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan in 2010) for the patients whose care we manage. SETMA has also designed and used a Daily Progress Note in our EMR. That project was suspended until we get an interface built between the hospital and NextGen so that daily vital signs and patient-condition data, laboratory values and medications can be automatically posted to our EM. We hope that will be accomplished with the deployment of our Health Information Exchange (HIE).

After reviewing the content of the Care Transitions Measurement Set, it was apparent that with a few modifications which have been made, SETMA performs all of the elements of this set. We believe that the auditing of this performance measure by the provider at the point of service will improve that quality of care given to patients transitioning from inpatient or ER to another place of care. The following links are discussions posted on SETMA's website about the complexities of care transitions.

<u>SETMA's Inpatient Team Based Process Analysis: The Interaction of SETMA's Hospital Care Team - Collegiality and "Electronic Huddles"</u>

SETMA's Care Coordination and Transitions of Care: Part I

A Care System for Effecting Reductions in Preventable Readmission Rates

CMMI Care Innovation Summit, Washington, D.C. January 26, 2012: Observations of an Attendee

Medical Home Series Two: Part VI Care Transitions

Patient-Centered Medical Home and Care Transitions: Part II

Patient-Centered Medical Home and Care Transitions: Part I

Reducing Preventable Readmissions to the Hospital

Concierge Medicine and the Future of Healthcare

Patient-Centered Medical Home - Care Coordination and Coordinated Care

SETMA and the National Quality Forum

The Future of Healthcare - SETMA's View

Passing the Baton: Effective Transitions in Healthcare Delivery

In addition, the method SETMA has developed to make the elements automatically interactive with the patient's care streamlines this process and makes it easy.

This Tutorial explains SETMA's deployment of this measurement set and how to use it. Currently, the Care Transition Data Set contains 18 elements. Fourteen or documentation elements and four are action elements. Please note that this is Phase I of the Care Transition Data Set; as this set evolves, SETMA will modify this deployment to reflect those upgrades.

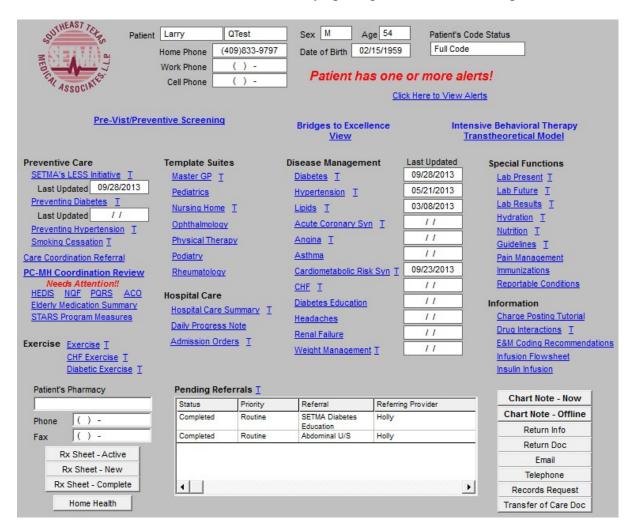
The following are links to SETMA's first 4.5 years of auditing of our use of the Care Transitions Data Set.

#### • Care Transition Audit

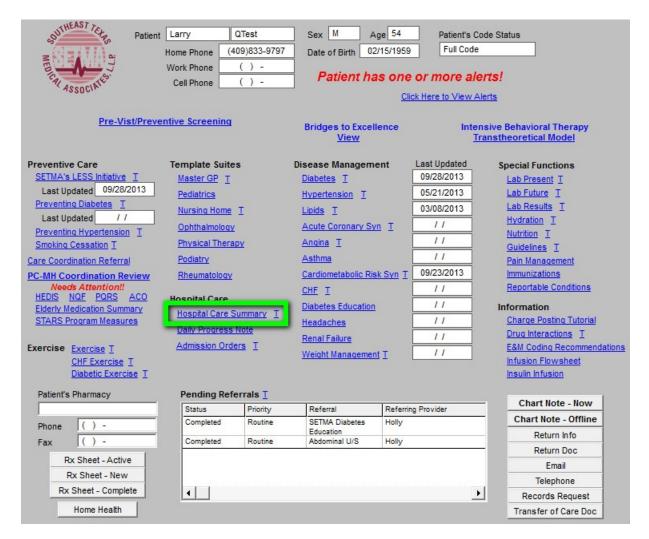
- 2013 Q-1,Q-2 Care Transition Audit
- <u>2012 Care Transition Audit</u>
- 2011 Care Transition Audit
- 2010 Care Transition Audit
- 2009 Care Transition Audit

#### How to use SETMA's Care Transition Audit

You will find the Care Transition Audit took by opening the AAA Home template



In previous iterations of this tool, the transitions audit was triggered off the Discharge Summary template. Now, however, the Discharge Summary has been renamed to Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan. The tutorial for that tool can be found at <a href="http://www.jameslhollymd.com/epm-tools/hospital-care-summary-and-post-hospital-plan-of-care-and-treatment-plan-tutorial">http://www.jameslhollymd.com/epm-tools/hospital-care-summary-and-post-hospital-plan-of-care-and-treatment-plan-tutorial</a>. The Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan is triggered off the button entitled Hospital Care Summary which is outlined in green below.



The Care Transition Audit button can be found at the bottom of the screen. Below it is outlined in green.

Hospital Car	Ad	Imission Date / /	Facility	SET Me	dical Center		Home
Hospital Car	Dis	scharge Date / /	Туре	Dischar	ge Summary		Histories
Summary	Schedule	ed Admission 🔘 Yes 🔘 No	Attending				Health
Admitting Diagnosis	Status	Discharge Diagnosis	S	tatus <u>Re-order</u>	Disabassis a Ta	9	System Review
		-			Discharging To		Physical Exam
		1	<del></del>		Discharge Conditi		
			<del></del>				Procedures
					Prognosis		Radiology
							EKG
					Readmission Risk	K _	Laboratory
					Low		Hydration
Additional Admitting Dx			Addition	al Discharge Dx	Discharge Time		Nutrition
		Discharge into Ch	ronic List		1 - 31 minutes > 31 minutes		Hospital Course
Admitting Chronic Condition	ns	Discharge Chronic Con	ditions	Re-order		_	
DM (diabetes mellitus) type II o		DM (diabetes mellitus) typ	e II controllec		Prison Inmate		Nursing Home
Chronic renal disease, stage I		Chronic renal disease, sta	age II		Days in ICU		Follow-up Instr
Diastolic CHF, chronic		Diastolic CHF, chronic			Days III ICO		Follow-up Loc
Malnutrition		Malnutrition			Days on IV Antibiotic	cs	Document
Chronic renal disease, stage I		Chronic renal disease, sta	age II				
Metabolic syndrome		Metabolic syndrome			Days on Ventilator		Follow-Up Doc
Hypertension		Hypertension					
Gout		Gout			Fall Risk Assessm	nent	08/21/2013
Hypertensive retinopathy of b		Hypertensive retinopathy			Functional Assess	ment	05/21/2013
Elevated blood uric acid level BPH without urinary obstruction		Elevated blood uric acid le			Pain Assessme	nt	09/13/2013
		BPH without urinary obstr	uction		Karnofsky/Lansky	Scale	1.1
Coronary artery disease Obesity, morbid		Coronary artery disease Obesity, morbid			Palliative Perf Sc	ale	1.1
Meniscus, lateral, derangemen		Meniscus, lateral, derange	ement		Last Hospital Discha		08/14/2013
Elevated C-reactive protein		Elevated C-reactive prote			Medication Reconcil		
Myocardial infarct, old		Myocardial infarct, old	-		Hospital Follow-Up	Call	
Elevated sed rate		Elevated sed rate			Surgeries This Stay		11
							11
							11
			<del></del>				
			<del></del>				
		Follow-Up Exceptions					
Care Transition Audit		Patient To Follow-Up W	/ith Non-SETM/	A Provider			
rust-Huspital rations Audit		Patient Ok To Follow-Up	p > 6 Days				

When that button is depressed, the following pop-up appears.

Has the reason for hospitalization been documented?	No Click to Update/Review
Have discharge diagnoses been entered?	No Click to Update/Review
Have the patient's medications been updated/reconciled	? Click to Update/Review
Have the patient's allergies been updated?  Also document allergies/reactions to medications.	No Click to Update/Review
Has the patient's cognitive status been documented?	No Click to Update/Review
Have pending results or tests been documented?	No Click to Update/Review
Have major procedures been documented?	No Click to Update/Review
Has a follow-up care plan been completed?	No Click to Update/Review
Has the patient's progress to goals/treatment been documented?	No Click to Update/Review
Have advanced directives been completed and a surrogate decision maker named or a reason given for not completing an advanced care plan?	Click to Update/Review
Has the reason for discharge been documented?	No Click to Update/Review
Has the patient's physical status been documented?	No Click to Update/Review
Has the patient's psychosocial status been documented	? Click to Update/Review
Has a list of available community resources been documented?	No Click to Update/Review
OR Has a list of coordinated referrals been documented?	No Click to Update/Review
Has the current/reconciled medication list been discussed with the patient/family/caregiver?	C Yes C No
Have the discharge orders been discussed with the patient/family/caregiver?	C Yes C No
Have the follow-up instructions been discussed with the patient/family/caregiver?	C Yes C No
Have the discharge materials been printed and given to the patient/family/caregiver?	C Yes C No

There are eighteen data points in the Care Transition Data Set. Fourteen are elements of documentation and four are actions which are to be taken. Once the discharge summary has been completed,

If the element has been met in the patient's record, or if the action required **has been taken**, two things will appear:

- 1. The element will appear in black fonts
- 2. The box next to the element will contain a "Yes" which will be in black fonts.

If the documentation or action required for an element in the Care Transition **has not been completed**, two things will appear:

- 1. The element will appear in red fonts
- 2. The box next to the element will contain a "No" which will be in red fonts.

To the right of each of the first fourteen elements of the data set, there is a button entitled "Click to update/review." When this button is depressed, it will automatically take you to the part of the discharge record which will allow you to document what is required but missing. In that the last four elements require an action, the documentation is completed by marking the "yes" or "no" radial button next to the element.

Has the reason for hospitalization been documented?	Click to Update/Review
Have discharge diagnoses been entered? No	Click to Update/Review
Have the patient's medications been updated/reconciled?	Click to Update/Review
Have the patient's allergies been updated?  Also document allergies/reactions to medications.	Click to Update/Review
Has the patient's cognitive status been documented?	Click to Update/Review
Have pending results or tests been documented?	Click to Update/Review
Have major procedures been documented?	Click to Update/Review
Has a follow-up care plan been completed?	Click to Update/Review
Has the patient's progress to goals/treatment been documented?	Click to Update/Review
Have advanced directives been completed and a surrogate decision maker named or a reason given for not completing an advanced care plan?	Click to Update/Review
Has the reason for discharge been documented?	Click to Update/Review
Has the patient's physical status been documented? No	Click to Update/Review
Has the patient's psychosocial status been documented? No	Click to Update/Review
Has a list of available community resources been documented?	Click to Update/Review
OR	_
Has a list of coordinated referrals been documented?	Click to Update/Review
Has the current/reconciled medication list been Yes C discussed with the patient/family/caregiver?	No III
Have the discharge orders been discussed with Yes C the patient/family/caregiver?	No II
Have the follow-up instructions been discussed Cayes Cowith the patient/family/caregiver?	No //
Have the discharge materials been printed and Yes Cipiven to the patient/family/caregiver?	No //

The eighteen elements are:

## 1. Has the reason for hospitalization been documented?"

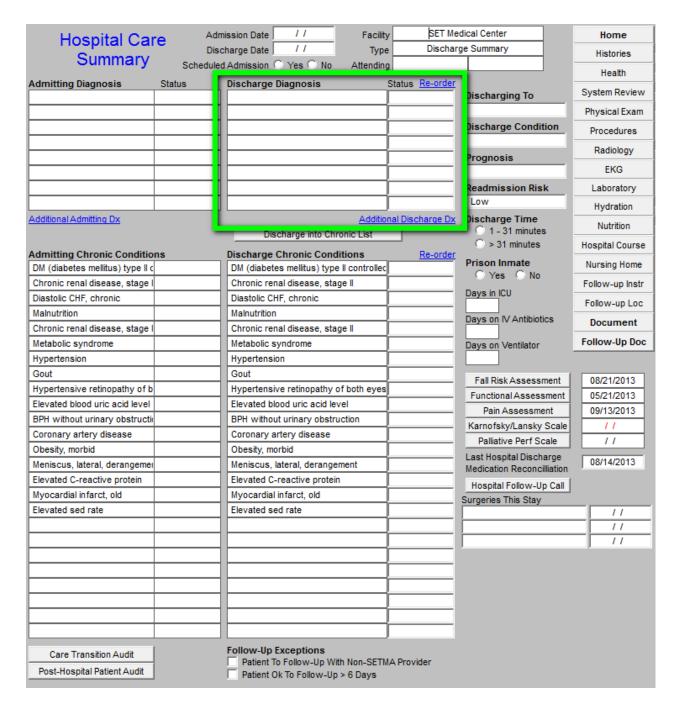
If the box next to this element indicates that it has not been documented, in which case a red "No" appears, depressing the "update/review" button displays the following template reason for hospitalization can be entered.

Admitted	Unassigne	patient? O Yes O No	Return  Add Treament Comments
Fluids Antimicrobial and Received IV medications		Patient Received  Breathing treatments of  Physical therapy Speech therapy Occupational therapy Radiation therapy Chemotherapy	
Diagnostics			Add Diagnostic Comments
Complications  No complications experienced Hospital course uneventful Gradual improvement took place  Response to Treatment	Diagnostic Tests Lab Patient developed a complic		Add Complication Comments  Add Response Comments
Patient responded to treatment  Abdominal tenderness has resolved Blood pressure control has been reesta Chest pain has resolved Chest x-ray and physical exam of lungs	Patient is afebrile	e were re-established	
Discharge Condition  Has improved Has deteriora Is ambulatory Is up in chair  Reason for Discharge	ted Stable but cont. to have pro	oblems Patient Deceased Cause of Death	Add Discharge Comments
Recovered from acute condition  Transferred to higher level of care	Maximum benefit reached in hospital setti	The state of the s	Patient expired Scheduled Read

The reason for hospitalization can then quickly be added to the record.

#### 2. "Have Discharge Diagnoses been entered?"

If the box next to this element indicates that it has not been documented, in which case a red "No" appears, depressing the "update/review" button displays the following template where the discharge diagnoses can be entered.

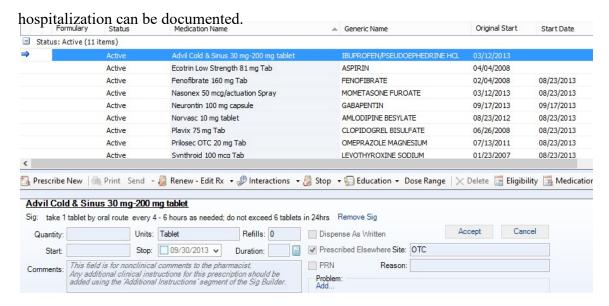


#### 3. "Have the patient's medications been updated/reconciled?

If the box next to this element indicates that it has not been documented, in which case a red "No" appears, depressing the "update/review" button displays the following template where the medications can be updated and/or reconciled.

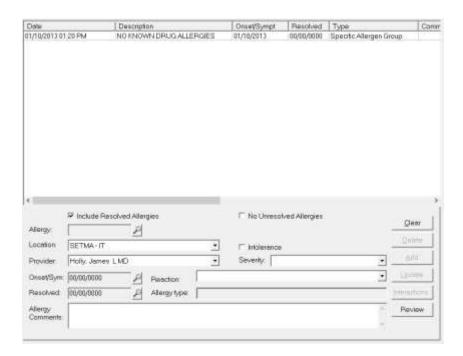
During the hospitalization process, SETMA's patients have four mediation reconciliations:

- a. Upon admission
- b. Upon discharge
- c. Care Coaching Call from SETMA's Care Coordination Department the day after discharge
- d. Follow-up visit in clinic: within two days for high risk readmission and within five days for other others.



## 4. "Have the patient's allergies been updated?" "Also, document allergies/reactions to medications."

If the box next to this element indicates that it has not been documented, in which case a red "No" appears, depressing the "update/review" button displays the following template where the allergies can be reviewed, updated and where any adverse reactions which took place during the



#### 5. "Has the patient's cognitive status been documented?"

If the box next to this element indicates that it has not been documented, in which case a red "No" appears, depressing the "update/review" button displays the Constitutional template of the

Constitutional Exam				
	Normal			
Level of Consciousness				
Orientation				
Level of Distress				
Nourishment				BMI
Overall Appearance				
Comments				
		ОК	Cancel	

## 6. "Have pending results or test been documented?"

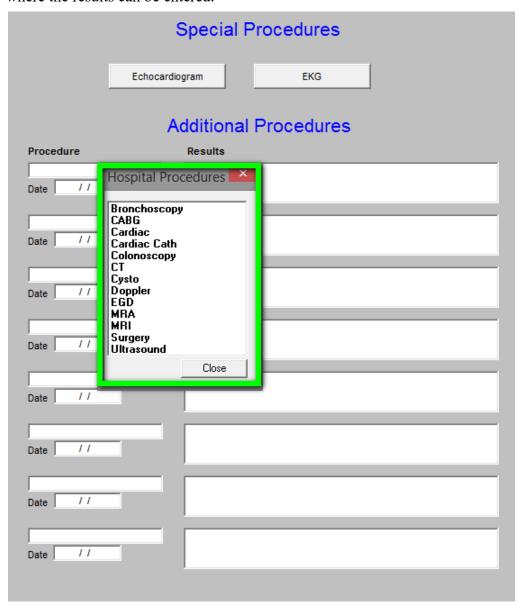
If the box next to this element indicates that it has not been documented, in which case a red "No" appears, depressing the "update/review" button displays the Hospital Course template where any pending or unreported tests can be denoted.

Admitted Through the ER	Other Facility	tal Course	57/4	Return
From the office  By elective admission			ext? Yes No	Add Treament Comments
Treated with IV Fluids Faids Antimicrobial and and Received IV medications	Received Blood Units Type		Allend Received Breathing treatments of Physical therapy Speech therapy Occapational therapy Radiation therapy Chemitherapy	
agnostics				Add Diagnostic Comments
te following were obtained and review prophications  No complications expensed magazini course uneventful	Despression Feet	developed a complicate		Add Complication Comments
Gradual improvement took place	Patient	was transferred to CU	for	
esponse to Treatment Palient responded to treatment		did not respond to treat		Add Response Comments
Abdomnal landerness has resolved filed pressure control has been re- Chest pain has resolved Chest x-ray and physical exam of lar	reliablished.   Neuro i	nd electrolyte belance w status has returned to n is afetrile		
scharge Condition	and a Property			Add Discharge Comments
Has improved Has deter is ambulatory is up in of	AND AND THE PARTY OF THE PARTY	but cont. to have proble ast	Ratent Deceased Cause of Death	
Recovered from scule condition	T. Harris or harrieff can	ched in hospital setting	Patient is stable	Patient expired   Scheduled Read
Transferred to higher level of care		ce for end of life care.	Transferred to LTAC	
Consults Last Name First Name	Cute Renad		Pending Tests/Results List any tests or results with Check here if none	ch are still pending. Lat Contact to Obtain Results
	11	- 6	A STATE OF THE PARTY OF THE PAR	The second secon
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	11		1	_

## 7. "Have major procedures been documented?"

If the box next to this element indicates that it has not been documented, in which case a red

"No" appears, depressing the "update/review" button displays the Major Procedures template where the results can be entered.



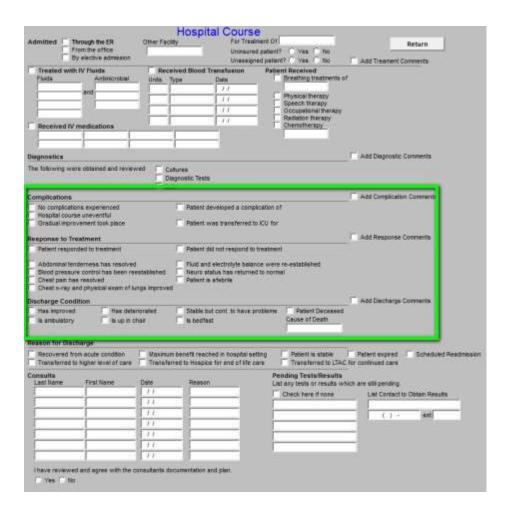
## 8. "Has a follow-up care plan been completed?"

If the box next to this element indicates that it has not been documented, in which case a red "No" appears, depressing the "update/review" button displays the Follow-up Plan template where the plan can be entered.

Hospital Follo	ow-Up
Hospital Discharge Instructions  Consult Home Health agency Consult Altus Home Health Discussed condition, medications, and follow-up care with patient and/or family Discharge to Nursing Home Give a copy of the Post Hospital Follow-up Document Home Rehab Home Speech Therapy Insure patient understands follow-up instructions Insure patient knows how to make follow-up appointment Review all follow-up instructions with patient Review medications with patient before discharge Send discharge summary, HP and consults to nursing home with patient Transport by Ambulance  SETMA Follow-Up Appointment  / / (Use 24 Hour Time)  Other Follow-Up Appointments  (Use 24 Hour Time)	Post Hospital Follow-Up Instructions  BMP, CBC, UA in 10 days Bring ALL medications to next office appointment Code - Full Code - Meds Code - No Continue medications per Post Hospital Follow-up document Daily Weight - if patient gains more than 3lbs in one day call MD Diet Discontinue smoking Elevate Limb Fall Risk Assessment Follow SETMA Guidelines as per Instructions Hydration Alert Notify Family of Readmission Notify CFNP of Readmission Portable Chest x-ray in 10 days PT/INR in Repeat labs in Skin Care Stop antibiotics in Sutures out in Weight Loss Alert
Reasons To Contact Provider  General Instructions  Asthma  Congestive Heart Failure  Pneumonia  GI Bleeding  Stroke	rction Surgery
Standard Nursing Home Discharge Orders Standard Home Discharge Orders OK Ca	ancel

#### 9. "Has the patient's progress to goals/treatments been documented?"

If the box next to this element indicates that it has not been documented, in which case a red "No" appears, depressing the "update/review" button displays the Hospital Course template where the progress to goals/treatments can be documented.



# 10. "Have advanced directives been completed and a surrogate decision maker selected or a reason given for not completing an advanced care plan?"

If the box next to this element indicates that it has not been documented, in which case a red "No" appears, depressing the "update/review" button displays the Advanced Directive Detail template.

Advanced Directives Detailed Information				
Advanced Directives Discussed?    Yes    No    Date Discussed    //				
Advanced Directives Completed?    Yes    No				
If no, specify reason.				
If yes, specifiy surrogate decision maker. Name Phone ( ) -				
Comments/Details				
OK Cancel				

#### 11. "Has the reason for discharge been documented?"

If the box next to this element indicates that it has not been documented, in which case a red "No" appears, depressing the "update/review" button displays the Hospital Course Template where the reason for discharge can be documented in the section provided.

	Hospital Course	e		
Admitted Through the ER	Other Facility For Treat	ment Of	Return	
From the office  By elective admission		d patient? O Yes O No		
		ed patient? O Yes O No	Add Treament Comments	
Treated with IV Fluids Fluids Antimicrobial and Received IV medications	Received Blood Transfusion Units Type Date  // / // / // / // / // / // / // / /	Patient Received  Breathing treatments of Physical therapy Speech therapy Occupational therapy Radiation therapy Chemotherapy	ıf	
Diagnostics			Add Diagnostic Comments	
The following were obtained and review	ed Cultures Diagnostic Tests Lab			
Complications			Add Complication Comments	
No complications experienced     Hospital course uneventful     Gradual improvement took place	Patient developed a comp			
Response to Treatment			Add Response Comments	
Patient responded to treatment	Patient did not respond to	treatment	<del></del> -	
Abdominal tenderness has resolved Blood pressure control has been reed Chest pain has resolved Chest x-ray and physical exam of lun	Patient is afebrile			
Discharge Condition Add Discharge Comments  Has improved Has deteriorated Stable but cont to have problems Patient Deceased				
Has improved Has deteri		roblems Patient Deceased Cause of Death		
Reason for Discharge				
Recovered from acute condition Transferred to higher level of care	Maximum benefit reached in hospital se Transferred to Hospice for end of life c	_	 □ Patient expired □ Scheduled Readmission ○ for continued care □	
Last Name First Name	Date Reason	List any tests or results w	hich are still pending.	
	11	Check here if none	List Contact to Obtain Results	
	11			
	11		( ) - ext	
	11			
	11			
	11			
	′′			
I have reviewed and agree with the co	nsultants documentation and plan.			

#### 12. "Has the patient's physical status been documented?"

If the box next to this element indicates that it has not been documented, in which case a red "No" appears, depressing the "update/review" button displays the Physical Examination section of the discharge summary.

Chief Complaints	Chronic Conditions	Positive
	DM (diabetes mellitus) type II c	Constitution
	Chronic renal disease, stage I	Head / Face
	Diastolic CHF, chronic	Eyes
	Malnutrition	Ears
	Chronic renal disease, stage I	
	Metabolic syndrome	Nasopharynx
	Hypertension	Neck / Thyroid
	Gout	Lymph Nodes
Vital Signs	Hypertensive retinopathy of b	Respiratory/Thorax
	Elevated blood uric acid level	Cardiovascular
Source of Information	BPH without urinary obstruction	Breast
Patient	Coronary artery disease	Abdomen / GI
Family member	Obesity, morbid	
Caregiver	Meniscus, lateral, derangemei	Genitourinary
Chart (Hospital Only)	Elevated C-reactive protein	Rectal
Chart (nospital Only)	Myocardial infarct, old	Back
	Elevated sed rate	Musculoskeletal
		Neurological
		Integumentary
		Psychiatric
		Foot

## 13. "Has the patient's psychosocial condition been documented?"

If the box next to this element indicates that it has not been documented, in which case a red "No" appears, depressing the "update/review" button displays the Functional Assessment template where the patient's psychosocial condition can be documented.

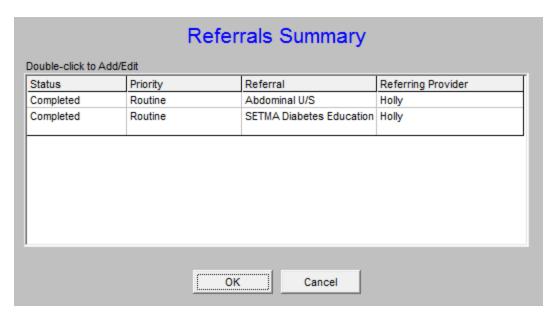
	Global Assessment of Functioning  Last Updated/Reviewed 05/21/2013
O 91 -100	Superior functioning in a wide rage of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many qualities. No symptoms.
C 90 - 81	Absent or minimal symptoms, good functioning in all areas, interested and involved in a wide range or activities, socially effective, generally satisfied with life, no more than everyday
80 - 71	If symptoms are present they are transient and expectable reactions to psychosocial stresses; no more than slight impairment in social, occupational, or school functioning.
C 70 - 61	Some mild symptoms OR some difficulty in social, occupational, or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships.
C 60 - 51	Moderate symptoms OR any moderate difficulty in social, occupational, or school functioning.
O 50 - 41	Serious symptoms OR any serious impairment in social, occupational, or school functioning.
C 40 - 31	Some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood.
C 30 - 21	Behavior is considered influenced by delusions or hallucinations OR serious impairment in communications or judgment OR inability to function in all areas.
C 20 - 11	Some danger or hurting self or others OR occasionally fails to maintain minimal personal hygiene OR gross impairment in communication.
C 10 - 1	Persistent danger of severely hurting self or others OR persistent inability to maintain minimum personal hygiene OR serious suicidal act with clear expectation of death.
	OK Cancel

# 14. "Has a list of available community resources and/or coordinated referrals been documented?"

If the box next to this element indicates that it has not been documented, in which case a red "No" appears, there are two options for fulfilling the element:

- A. For those patients not being followed-up in a SETMA clinic depressing the "update/review" button displays Local Available Services template which will allow you to refer them to a local clinic.
- B. For those patients who are being followed by SETMA, you would simply complete any referrals which need to be done by utilizing the referral template function which is displayed on the Discharge Master

Local Available Services				
Gulf Coast Health Care Center, Inc.	Jefferson County Public Health Department			
2548 Memorial Blvd. Port Arthur, Texas 77640 (409) 983-1161	Health & Welfare Unit #1 1295 Pearl Beaumont, Texas 77701 (409) 835-8530			
601 Rev Dr Ransom Howard St Pt Arthur, Texas 77642 (409) 983-1161	Health & Welfare Unit #2 246 Dallas Port Arthur, Texas 77640			
1301 West Park Ave Ste C Orange, Texas 77630 (409) 886-4400	(409) 983-8380  Ibn Sina Community Medical Center  8599 9th Ave			
710 Hwy 327 East Silsbee, Texas 77656 (409) 386-1222	Pt. Arthur, Texas 77642 (409) 724-7462			
	Legacy Community Health Services			
103 West Gibson Ste 110 Jasper, Texas 75951 (409) 489-9103	4450 Highland Beaumont, Texas 77705 (409) 242-2525			



The last four elements are actions which need to be taken and simply requiring checking whether or not these four functions have taken place.

Care Transition Audit	OK Cancel
Has the reason for hospitalization been documented?	No Click to Update/Review
Have discharge diagnoses been entered?	No Click to Update/Review
Have the patient's medications been updated/reconciled	? No Click to Update/Review
Have the patient's allergies been updated?  Also document allergies/reactions to medications.	No Click to Update/Review
Has the patient's cognitive status been documented?	No Click to Update/Review
Have pending results or tests been documented?	No Click to Update/Review
Have major procedures been documented?	No Click to Update/Review
Has a follow-up care plan been completed?	No Click to Update/Review
Has the patient's progress to goals/treatment been documented?	No Click to Update/Review
Have advanced directives been completed and a surrogate decision maker named or a reason given for not completing an advanced care plan?	No Click to Update/Review
Has the reason for discharge been documented?	No Click to Update/Review
Has the patient's physical status been documented?	No Click to Update/Review
Has the patient's psychosocial status been documented	? No Click to Update/Review
Has a list of available community resources been documented?	No Click to Update/Review
OR	No Click to Update/Review
Has a list of coordinated referrals been documented?	
Has a follow-up call been scheduled?	No Click to Update/Review
Has the current/reconciled medication list been discussed with the patient/family/caregiver?	○ Yes ○ No
Have the discharge orders been discussed with the patient/family/caregiver?	© Yes © No
Have the follow-up instructions been discussed with the patient/family/caregiver?	© Yes
Have the discharge materials been printed and given to the patient/family/caregiver?	© Yes

By checking each of these boxes the provider or his/her representation attests to the fact that:

- 1. Medications have been discussed with patient.
- 2. Discharge orders have been discussed with pateint.
- 3. Follow-up instructions have been discussed wit the patient.
- 4. Discharge materials have been printed and given to the patient/family/caregive.

Bewteen 2008 and 2013, SETMA has discharge 21,000 patients from the hopstial. Int hat time 98.7% of the time these tools have been given to the patient at the time they leave the hospital.

Note: In 2011, The AMA's PCPI Department completed a research project on SETMA's use of their Care Transitions Meawsurement Set. The conclusion of that project was the SETMA is using the set correctly and that our audit results are accurate.