James L. Holly, M.D.

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Ms. Angela Zambeaux
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Dear Ms. Zambeaux:

Identification of Proposed *Always Event*

In 2001, Southeast Texas Medical Associates (SETMA, www.jameslhollymd.com) began completing the *Hospital Discharge Summary* in the same ambulatory electronic health record (EHR) used in the clinic and in 2010, SETMA changed the name of this document to *Hospital Care Summary and Post-Hospital Plan of Care and Treatment Plan*. Over the past five years, this document has been completed and given to the patient and/or family, 98.7% of the time at the patient's discharged from the hospital, a total of over 21,000 hospital discharges.

***Always Events*/Experiences Criteria**

Significant – SETMA's Transition-of-Care document, *The Hospital Care Summary and the Post-Hospital Plan of Care and Treatment Plan*, is one of five steps in SETMA's Transition-of-Care process which begins upon hospital admission and concludes when the patient is seen in the clinic by the primary care provider after leaving the hospital. This patient activation-and-engagement document is presented with explanation to the patient and/or family before the patient leaves the hospital and forms the foundation of SETMA's and the patient's shared-decision making hospital-discharge process. This *Always Event* is foundational to SETMA's quality of care and patient safety program as it establishes a reconciled medication list, scheduled follow-up care with provider identification, time, date and place of follow-up within two to five days of leaving the hospital, and a 12-30 minute care coaching call from SETMA's Department of Care Coordination the day following discharge (the following is a link to other articles about SETMA's care transitions work: http://www.jameslhollymd.com/your-life-your-health/care-transitions.

Evidenced-based – SETMA is recognized/accredited as a Patient-Centered Medical Home (PC-MH) by NCQA (2010-2016), AAAHC (2010-2017), URAC (2014-2017) and The Joint Commission (2014-2017) and employs *Hospital Consumer Assessment of Healthcare Provider and Systems* (HCAHPS, http://www.jameslhollymd.com/epm-tools/SETMAs-Internal-HCAHPS-Survey-Tutorial), *Consumer Assessment of Healthcare Providers and Systems* (CAHPS, http://www.jameslhollymd.com/Your-Life-Your-Health/pdfs/ncqas-new- distinction-in-patient-experience-reporting.pdf), along with SETMA's *Community Council* (http://www.jameslhollymd.com/Your-Life-Your-Health/pdfs/setmas-community-council.pdf), to measure the patient- centeredness of care. Whether patient safety, quality of care, reduction of preventable readmissions, or the pursuit of the Triple Aim, SETMA's *Hospital Care Summary and Post-Hospital Plan of Care and Treatment Plan* fulfills the highest standards of evidence-based transitions of care and of PC-MH demands for patient-

centeredness. The evidenced-based requirements for this document to be personalized, written, comprehensible, comprehensive, and presented in a timely manner, are fulfilled by SETMA's deployment.

Measurable – This *Always Event* is measured by the patient and/or family physically receiving the Transitions of Care Document. But more than a piece of paper being perfunctorily given to the patient, this event is measured by the effectiveness of the patient's transition from the inpatient to the ambulatory setting. There are eight different potential destinations for this transition. Each has unique characteristics depending upon the level of care being provided. The most significant measure is the Post Hospital Care Coaching Call the day following discharge which allows the SETMA staff to assess the effectiveness of the transition of care process. A re-admission within thirty days is considered a failure of the transition of care process and inquiry is made to understand why the failure occurred and how to avoid another failure in the future.

Affordable – This *Always Event* criteria may be unrealistic if measured as a totally new undertaking prior to practice transformation as a PC-MH. However, the adaptation of an existing EHR, patient-centric practice style and PC-MH structure and methodology of practice, with the ability to capture new revenue with the CMS Transitions of Care codes, makes the process not excessively costly. The following is an explanation and tutorial to SETMA's deployment of CMS's transitions of care codes: http://www.jameslhollymd.com/epm- tools/transition-of-care-management-code-tutorial.

Foundational Elements

Partnerships with Patients and Families – SETMA healthcare providers and staff follow a protocol for the fulfillment of HCAHPS all of which measures contribute to the patient/provider partnership in quality and safety of care. The issues addressed are, "during this hospital stay, how often did doctors: treat you with courtesy and respect; listen carefully to you; explain things in a way you could understand; talk with you about whether you would have the help you needed when you left the hospital; did you get information in writing about what symptoms or health problems to look out for after you left the hospital?" Both a hospital-employed vendor and SETMA's Department of Care Coordination address these and other issues. One of the principal functions of SETMA's Community Council will be patient input on the patient's experience of care transitions and their recommendation for how we can improve that experience.

Leadership – The formal leadership of SETMA is the Governance Board; details of the Board's support of this and every quality improvement initiative at SETMA can be found at www.jameslhollymd.com under Governance. (see http://www.jameslhollymd.com/Governance-Board/pdfs/maintaining-a-culture-of-safety-and-quality.pdf) SETMA's leadership can best be described by "Kaizen," is a Japanese word meaning, "a system of continuous improvement in quality, technology, processes, company culture, productivity, safety and leadership.
SETMA's leadership has supported the ideals of patient-centric care and the reality of a hospital-care team which supports this transition-of-care program. Through monthly, one-half day training sessions for all providers, SETMA's leadership disseminates, encourages and supports patient-centric care throughout the organization, not just in the care transitions efforts.

Staff Engagement – Fourteen years ago, SETMA developed a hospital-care team which staffs SETMA's inpatient care around the clock. That team, made up of RNs, CFNPs and physicians, maintains continuity of care, transitions of care, quality of care and patient safety. That team interfaces with the hospital staff and through monthly meetings with hospital administration. Through the SETMA Foundation and the Department of Care Transitions, this team makes certain that no patient leaves the hospital without SETMA knowing that all of their home-care needs, including medications and safety, are met. When SETMA began developing a "developmental history of SETMA," it was evident that more than electronic health records and electronic patient management, SETMA's progress was a function of staff/provider teamwork.

Evaluation and Outcome -- In order both to prove and to improve our performance of this *Always Event*, in 2009, SETMA began public reporting by provider name our provider performance on the Physician Consortium for Performance Improvement (PCPI)on their Care Transitions Quality Metric Set which is composed of fourteen performance elements and four actions (http://www.jameslhollymd.com/EPM-Tools/pdfs/care-transition- tutorial.pdf) . SETMA's tutorial for this process is found at: http://www.jameslhollymd.com/epm-tools/hospital-care- summary-and-post-hospital-plan-of-care-and-treatment-plan-tutorial. This material is available free of charge
and can be used without attribution. SETMA's measurement of provider performance is publicly reported by provider name for 2009—2014 at: http://www.jameslhollymd.com/public-reporting/public-reports-by-type. In 2011, the American Medical Association's PCPI Section performed an analysis of SETMA's use of the Transitions of Care Quality Measurement Set to see if we were using the measures correctly and accurately. The conclusion of the study was that we were and that we are fulfilling the spirit and the letter of the measures. SETMA's data analysis of preventable readmissions allows us to measure the effectiveness of our transitions of care process.

Evidence of Institutional Commitment – SETMA's CEO, COO, and Chief information officer are committed to the effectiveness, excellence and sustainability of this Always Event. They are supported by the Governance Board and by the various teams which support the principles and ideals of SETMA's PC-MH.

SETMA's Transition-of-Care *Always Event* is successfully completed over 98% of the time and is supported by SETMA's Governance Board, Executive Management, Hospital Care Team and I-Care team, which is SETMA's long-term, residential care support team. The following is a link to a two-minute video about SETMA's Transition of Care program: SETMA's Care Transitions to Reduce Preventable Hospital Readmissions.

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