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Transition of Care - One form of Care Coordination

Transitions of Care is one of the forms of Care Coordination

- **Care Transitions: The Heart of PC-MH**
  In SETMA's Model of Care -- Care Transition involves:

  1. Evaluation at admission -- transition issues : "lives alone," barriers , DME, residential care, or other needs
  2. Fulfillment of PCPI Transitions of Care Quality Metric Set
  3. Post Hospital Follow-up Coaching -- a 12-30 minute call made by members of SETMA's Care Coordination Department
  4. Plan of Care and Treatment Plan
  5. Follow-up visit with primary provider

- **Hospital-Care-Summary-and-Post-Hospital-Plan-of-Care-and-Treatment-Plan-Tutorial**

While the traditional "discharge summary" should have been the most important document created during a patient's hospital stay, it historically came to be nothing but a document created for an administrative and billing function for the hospital and attending physician. It has long cease to being a dynamic document for the improvement of patient management. The "discharge summary" rarely provided continuity of care value, or transitions of care information, such as diagnoses, reconciled medication list, or follow-up instructions. In reality, the "discharge summary" was often completed days or weeks after the discharge and was a perfunctory task which was only completed when hospital staff privileges were threatened or payment was delayed.

The "discharge summary" should have always been a transition-of-care document which not only summarized the patient's care during the hospitalization but guided the patient's post-hospital care with a plan of care and treatment plan. In this way, the document would have been a vehicle for patient engagement and activation.

Changing the Name to Clarify the Function

In September, 2010, SETMA representatives as an invited participate attended a National Quality Forum conference on Transitions of Care. (http://www.setma.com/Letters/nqf-summary-of-dr-hollys-comments-sept-2-2010) During that conference, SETMA realized that the name "discharge summary" needed to be changed. It was thought that a name change would clarify and focus the intent of this critical document. The name was changed to "Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan."

- **Medical-Home-Plan-of-Care-and-Treatment-Plan**

While transitions of care are most commonly thought of as being from inpatient to outpatient, every time a patient eaves a provider's office, a transition of care takes place. The transition is from the provider to the patient being the principle party responsible for the patient's care. In fact, the patient is reasonable for their own care for more of the time than is the provider. The patient's "baton," - their treatment plan and plan of care - empowers then to "take care of their own health for over 8,740 hours a year.

- **Passing the Baton - Effective Transitions in Healthcare Delivery**

No matter how talented the members of a relay team are, the most critical point of their collective performance is in the transition from one runner to another. At this point, one runner, moving as fast as he/she can, must hand the baton to another runner, who has started running as fast as he/she can, before the first runner has even arrived in the

"transfer zone." As if this were not complex enough, the rules of the race require that the transfer of the baton must take place within a certain zone.

If the baton is dropped or if the transfer is not made in the prescribed time, the team, no matter how gifted will be disqualified and will lose the race. As with life and with healthcare, it is not always the brightest, fastest, best person who wins. It is the person, in this case, the team, which not only performs well in their individual area of responsibility but who also performs well in transferring the results of his/her performance to the next participant and who does so within the constraints of the rules.*Often, it is forgotten that the member of the healthcare delivery team who carries the "baton" for the majority of the time is the patient and/or the family member who is the principal caregiver. If the "baton" is not effectively transferred to the patient or caregiver, then the patient's care will suffer.*

In healthcare there are transition points-of-care, where the "baton", which now represents the transfer-of-care responsibility from one person to another, must be smoothly, efficiently and timely accomplished, or the value of the care provided by each care giver will be diminished to the point that the overall quality of care may be less than the sum of the contributions of each care giver. This diminishing of the value of care occurs when only a small part of the value of each participant's contribution is successfully transferred to the next point-of-care. This occurs when the "baton" is dropped.

- **Summary of Care Transitions**

Patient-Centered Medical Home and Care Transitions: Part I

Patient-Centered Medical Home and Care Transitions: Part II

Care Transition is the heart of the patient-centered medical Home. It fulfills many of the elements of the National Priorities Partnership in which the National Quality Forum identified Priorities for the 2011 National Quality Strategy.

These are:

1. Wellness and Prevention
2. Safety
3. Patient and Family Engagement
4. Care Coordination
5. Palliative and End of Life Care

- **Care Transition Data Set from PCPI Tutorial**

- **Transitions of Care Management Coding (TCM Code) Tutorial**

In January, 2013, CMS published two new Evaluation and Management Codes (E&M Codes) which were adopted in order to recognize the value of the processes of transitioning patients from multiple inpatient sites to multiple outpatient venues of care. The value of this work is now being recognized by enhanced reimbursement. CMS has also published three codes for Complex Chronic Care Coordination, which is considered bundled payments in 2013 but in 2014 are scheduled for additional payment to primary care providers.

- **Transitions of Care to Reduce Preventable Readmissions**

  The focus in care coordination addressed by National Priorities Partnership are the links between:

  - **Care Transitions**,- ,...continually strive to improve care by,...considering feedback from all patients and their families,...regarding coordination of their care during transitions between healthcare systems and services, and,...communities.
  - **Preventable Readmissions**,- ,...work collaboratively with patients to reduce preventable 30-day readmission rates.

- **Improving SETMA's Care Transitions and Care Coordination**