Care Transitions: The heart of Patient-Center Medical Home

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Care Transitions

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 and additional support
4. **Plan of Care and Treatment Plan**
5. **Follow-up visit with primary provider**

National Priorities Partnership

National Priorities Partnership
National Quality Forum
Input to the Secretary of HHS
Priorities for the 2011 National Quality Strategy

- Wellness and Prevention
- Safety
- Patient and Family Engagement
- Care Coordination
- Palliative and End of Life Care

National Priorities Partnership

Addressing the fourth NPP goal, the NQF report to HHS stated that in regard to care coordination:

"Healthcare should guide patients and families through their healthcare experience, while respecting patient choice, offering physical and psychological supports, and encouraging strong relationships among patients and the healthcare professionals accountable for their care…."

National Priorities Partnership

Focus in care coordination by NPP 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.

Care Transitions & Hospital Readmission

In SETMA's experience, there are fifteen steps required to address care coordination and hospital readmissions, as a function of a quality care initiative which is sustainable.

The steps and the solution for each are as follows.

Care Transitions & Hospital Readmission

1. In January,1999, SETMA began using the EHR to document patient encounters. In May, 1999, SETMA modified the goal to **electronic patient management** (EPM) in order to leverage the power of electronics to improve treatment outcomes. In October, SETMA began using the EMR in the hospital for **hospital H&Ps**, creating continuity-of-care process, based on healthcare data being electronically created and being available at all points of care.

Care Transitions & Hospital Readmission

2. In 2000, realizing that excellent care in the 21st Century was going to be team-based, SETMA formed a **hospital service team,** which provides 24-hour-a-day, seven-day a week, in-house coverage for all of our patients.

Care Transitions & Hospital Readmission

3. In 2001, SETMA began using the EHR to produce hospital **discharge summaries** which further advanced continuity-of-patient-care and established the groundwork both for care transitions and for effectively addressing preventable readmissions.

   At this point, **medication reconciliation** could take place in the: clinic, hospital, nursing home, home health and emergency department.

Care Transitions & Hospital Readmission

4. In 2003, SETMA designed **hospital-admission-order sets**, based on national standards of care, which created a consistency of treatment plans and eliminated delay in the initiation of excellent care.

Care Transitions & Hospital Readmission

5. Also ,in 2003, SETMA began using the EHR in all **twenty-two nursing homes** we staff. Because our patients' care is managed in the same electronic data base, whether in the ambulatory setting, hospice, home health, physical therapy, hospital, emergency department, or nursing home, there is a continuity-of-care which is data and information driven.

Care Transitions & Hospital Readmission

6. In 2004, SETMA designed an electronic, **Inpatient Medical Record Census** (IMRC); deployed on SETMA's intranet and HIPPA compliant, the IMRC allows searchable-data recording of:

   a. date of admission to the hospital
   b. place of admission
   c. date and time of completion of the History and Physical
   d. date of discharge
   e. date and time of completion of the **Hospital Care summary and post-hospital plan of care and treatment plan**.
   f. Posting of questions from business office which need research by hospital care team.

Care Transitions & Hospital Readmission

7. In 2007, SETMA's partners realized that many of our patients, even those with insurance, cannot afford all of their health care. This resulted in the creation of **The SETMA Foundation**.

   SETMA partners have given over $1,500,000 to the Foundation which pays for medications, surgeries and other care, such as dental, for our patients who cannot afford it.

Care Transitions & Hospital Readmission

8. In June, 2009, the **Physician Consortium for Performance Improvement (PCPI)** published the first national quality measurement set on **Care Transitions**; the same month, SETMA deployed the measures in our EHR. Since then, of the 2995 discharges from the hospital, 99.1% have had the Hospital Care Summary completed at the time the patient left the hospital.

Care Transitions & Hospital Readmission

9. October, 2009, SETMA adapted a **Business Intelligence tool to create an audit** of hospitalized patients to examine differences between patients who are re-admitted and those who are not. The audit looks at: gender, ethnicity, socio-economic issues, social isolation, morbidities and co-morbidities, lengths of stays, age, timing of follow-up after discharge, whether a follow-up call was received and other issues. T**hese measures look for leverage points for "making a change, which will make a difference in readmissions"**

Care Transitions & Hospital Readmission

10. November, 2009, SETMA began **publicly reporting performance** on over 200 quality metrics **by provider name** at www.setma.com. Disease management plans-of-care documents for diabetes, hypertension, and cholesterol, include the provider performance on that patient's care, as judged by these quality metrics.

Care Transitions & Hospital Readmission..

11. In July, 2010, pursuant to becoming a Tier 3 PC-MH, SETMA created a **Department of Care Coordination**, which is tasked with:

- Post Hospital follow-up calling
- Completing SETMA Foundation Referrals
- Patient counseling for barriers to care
- Establishing continuity of care
- Engaging patients in their own care
- Alerting providers to patients' special needs
- Another level of mediation reconciliation

Care Transitions & Hospital Readmission”

12. September, 2010, at a National Quality Forum workshop on Care Transitions, SETMA realized that the term “discharge summary” was outdated. We changed the name to “**Hospital Care Summary and Post Hospital Plan-of-Care and Treatment-Plan**,” long and perhaps awkward, this name, is functional, focusing on the unique elements of Care Transition which contribute to the foundation for a sustainable plan for addressing preventable readmissions to the hospital.

Care Transitions & Hospital Readmission

13. In 2010, SETMA deployed both a **secure web portal** and a **health information exchange** to allow the seamless exchange of information between the hospitals , nursing homes, home health agencies, hospices, and SETMA. The HIE has been expanded to a seven-county project including all healthcare providers and agencies, which will ultimately be the key to preventing readmission to the hospital.

Care Transitions & Hospital Readmission

14. Since 1997, SETMA has partnered with a **Medicare Advantage home health** agency, with other home health agencies and with **free-standing hospices** to provide compassionate, competent care for our patients in settings other than hospital inpatient to reduce readmissions of our most vulnerable patients while providing excellent care to them.

Care Transitions & Hospital Readmission

15. As a **Patient-Centered Medical Home**, SETMA makes certain that the Hospital Care Summary and Post Hospital Plan of Care and Treatment is transmitted to the next site of care as the "baton," (see below). **With these care coordination, continuity of care and patient-support functions, SETMA believes that we are ready to make a major effort to decrease preventable readmissions to the hospital.**

Care Transitions & Hospital Readmission

These tools and functions have allowed sustainable improvements. For example:

- In February, 2011, during one weekend, SETMA discharged 26 patients in two days.
- Most of these discharges were challenging, but all were treated all through SETMA's standard procedures and processes described above.
- Over the next 60 days, 6.8% were readmitted.

Care Transitions

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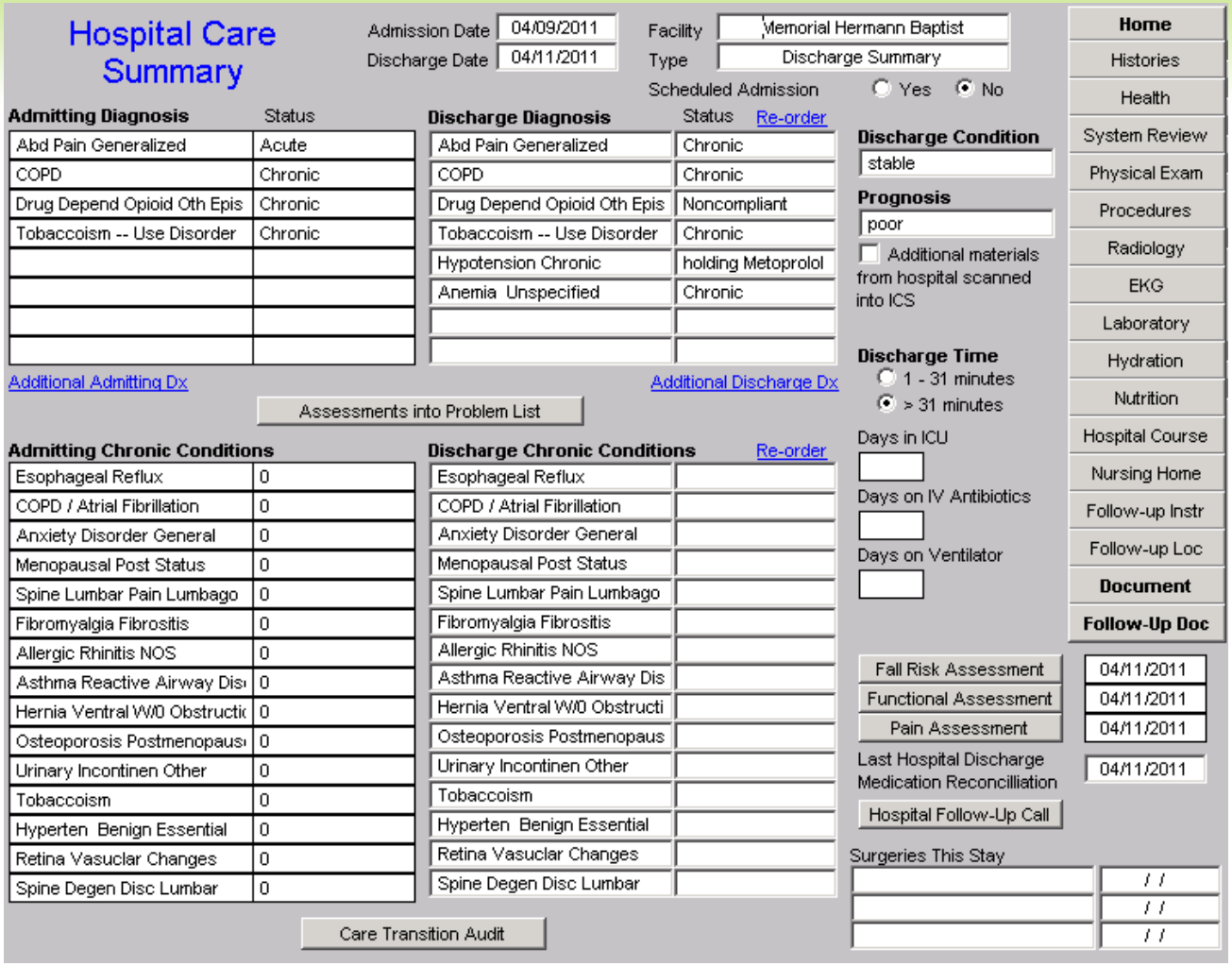
5. **Follow-up visit with primary provider**

Hospital Care Summary

SETMA's Hospital Care Summary is a suite of templates with which the transition of care document Is created. (A full tutorial of these templates can be found on our website at www.setma.com under "**Electronic Patient Tools**" at "**Hospital Based Tools**.")

The following is a screen shot of the Master Discharge Template entitled "**Hospital Care Summary**". This screen shot is from the record of a real patient whose identify has been removed.

Hospital Care Summary



Hospital Care Summary

Admission Date 04/09/2011
Discharge Date 04/11/2011
Facility Memorial Hermann Baptist
Type Discharge Summary
Scheduled Admission ○ Yes ◉ No

Admitting Diagnosis	Status
Abd Pain Generalized	Acute
COPD	Chronic
Drug Depend Opioid Oth Epis	Chronic
Tobaccoism -- Use Disorder	Chronic

Additional Admitting Dx

Discharge Diagnosis	Status (Re-order)
Abd Pain Generalized	Chronic
COPD	Chronic
Drug Depend Opioid Oth Epis	Noncompliant
Tobaccoism -- Use Disorder	Chronic
Hypotension Chronic	holding Metoprolol
Anemia Unspecified	Chronic

Additional Discharge Dx

Assessments into Problem List

Admitting Chronic Conditions	
Esophageal Reflux	0
COPD / Atrial Fibrillation	0
Anxiety Disorder General	0
Menopausal Post Status	0
Spine Lumbar Pain Lumbago	0
Fibromyalgia Fibrositis	0
Allergic Rhinitis NOS	0
Asthma Reactive Airway Dis	0
Hernia Ventral W/0 Obstructi	0
Osteoporosis Postmenopaus	0
Urinary Incontinen Other	0
Tobaccoism	0
Hyperten Benign Essential	0
Retina Vasuclar Changes	0
Spine Degen Disc Lumbar	0

Discharge Chronic Conditions (Re-order)	
Esophageal Reflux	
COPD / Atrial Fibrillation	
Anxiety Disorder General	
Menopausal Post Status	
Spine Lumbar Pain Lumbago	
Fibromyalgia Fibrositis	
Allergic Rhinitis NOS	
Asthma Reactive Airway Dis	
Hernia Ventral W/0 Obstructi	
Osteoporosis Postmenopaus	
Urinary Incontinen Other	
Tobaccoism	
Hyperten Benign Essential	
Retina Vasuclar Changes	
Spine Degen Disc Lumbar	

Care Transition Audit

Discharge Condition: stable

Prognosis: poor

☐ Additional materials from hospital scanned into ICS

Discharge Time
○ 1 - 31 minutes
◉ > 31 minutes

Days in ICU
Days on IV Antibiotics
Days on Ventilator

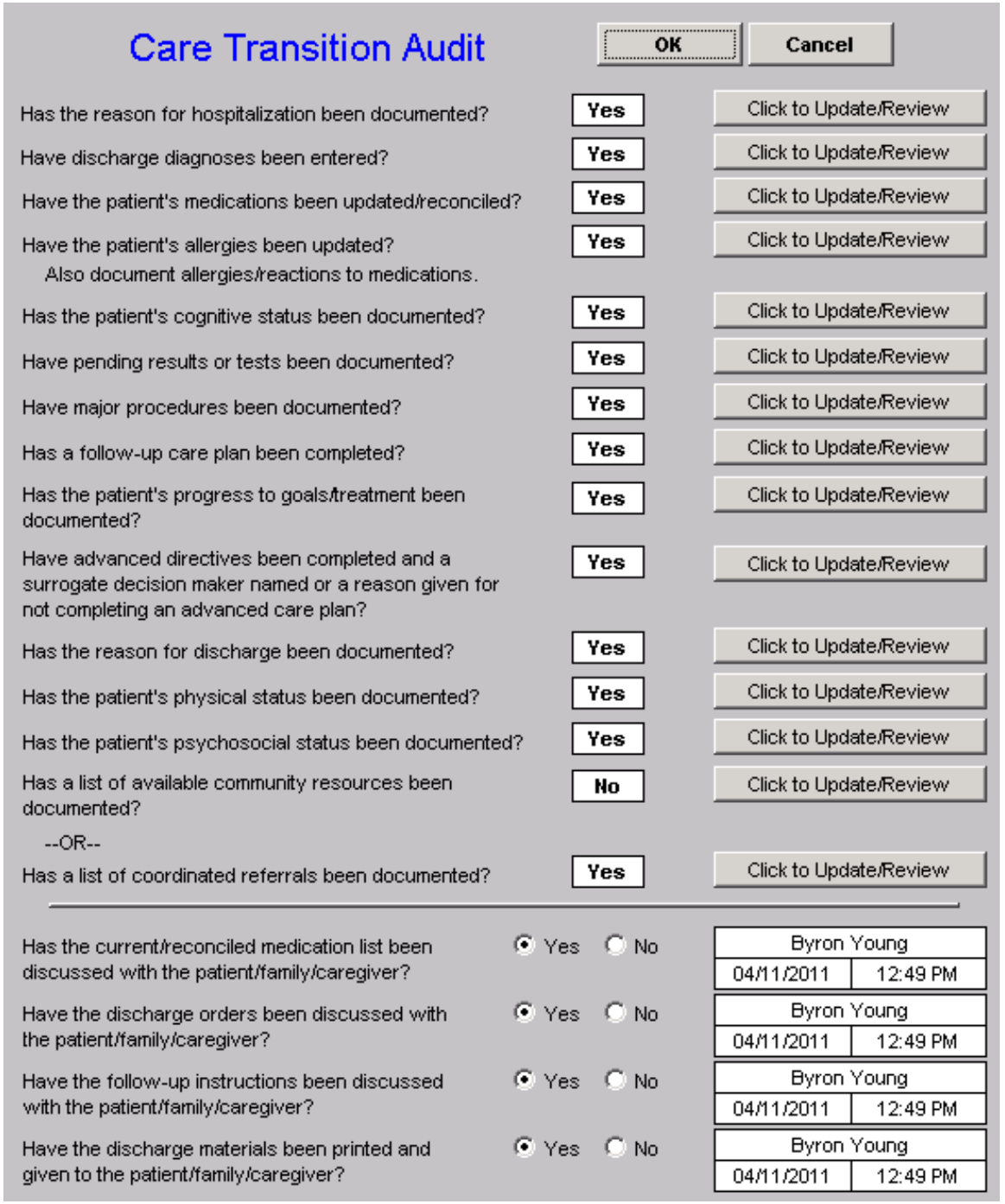
Fall Risk Assessment 04/11/2011
Functional Assessment 04/11/2011
Pain Assessment 04/11/2011
Last Hospital Discharge Medication Reconcilliation 04/11/2011
Hospital Follow-Up Call

Surgeries This Stay
/ /
/ /
/ /

Home
Histories
Health
System Review
Physical Exam
Procedures
Radiology
EKG
Laboratory
Hydration
Nutrition
Hospital Course
Nursing Home
Follow-up Instr
Follow-up Loc
Document
Follow-Up Doc

Care Transition Audit

At the bottom of this template, there is a button Entitled "**Care Transitions Audit**." Once the suite of Templates associated with the Hospital Care Summary has been completed, the provider depresses this button and the system automatically aggregates the data which has been documented and displays which of the 18-data points have been completed and which have not.


Care Transition Audit
OK
Cancel
Has the reason for hospitalization been documented?
Yes
Click to Update/Review
Have discharge diagnoses been entered?
Yes
Click to Update/Review
Have the patient's medications been updated/reconciled?
Yes
Click to Update/Review
Have the patient's allergies been updated?
Also document allergies/reactions to medications.
Yes
Click to Update/Review
Has the patient's cognitive status been documented?
Yes
Click to Update/Review
Have pending results or tests been documented?
Yes
Click to Update/Review
Have major procedures been documented?
Yes
Click to Update/Review
Has a follow-up care plan been completed?
Yes
Click to Update/Review
Has the patient's progress to goals/treatment been documented?
Yes
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?
Yes
Click to Update/Review
Has the reason for discharge been documented?
Yes
Click to Update/Review
Has the patient's physical status been documented?
Yes
Click to Update/Review
Has the patient's psychosocial status been documented?
Yes
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?
Yes
Click to Update/Review
Has the current/reconciled medication list been discussed with the patient/family/caregiver?
Yes
No
Byron Young
04/11/2011
12:49 PM
Have the discharge orders been discussed with the patient/family/caregiver?
Yes
No
Byron Young
04/11/2011
12:49 PM
Have the follow-up instructions been discussed with the patient/family/caregiver?
Yes
No
Byron Young
04/11/2011
12:49 PM
Have the discharge materials been printed and given to the patient/family/caregiver?
Yes
No
Byron Young
04/11/2011
12:49 PM

Care Transition Audit

The elements in black have been completed; any in red have not. If an element is incomplete, the provider simply clicks the button entitled "Click to update/Review." The missing information can then be added. This fulfills one of SETMA's principles of EHR design which is "**We want to make it easier to do it right than not to do it at all**."

Care Transition Audit

Quarterly and annually, SETMA audits each provider's performance on these measures and publishes that audit on our website under "**Public Reporting**," along with over 200 other quality metrics which we track routinely.

The following is the care transition audit results by provider name for 2010.

Care Transition Audit

Care Transition Audit (Section A)

Discharge Date(s): 01/01/2010 through 12/31/2010

Provider	Reason for Hospitalization	Discharge Diagnoses	Medications Updated Reconciled	Documentation of Allergies	Cognitive Status	Pending Test Results	Major Procedures	Follow-Up Care Plan	Progress to Goals Response to Treatment
Ahmed	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Anwar	95.0%	100.0%	82.4%	88.9%	93.5%	92.9%	90.7%	93.7%	95.0%
Aziz	98.4%	100.0%	95.2%	94.7%	96.7%	98.2%	95.6%	97.2%	95.6%
Colbert	100.0%	100.0%	50.0%	50.0%	83.3%	100.0%	66.7%	100.0%	100.0%
Cricchio	91.7%	94.4%	94.4%	91.7%	94.4%	91.7%	88.9%	88.9%	91.7%
Curry	99.1%	100.0%	97.2%	95.3%	96.2%	100.0%	95.3%	98.1%	98.1%
Deiparine	97.7%	100.0%	90.0%	95.8%	97.2%	96.3%	95.6%	96.3%	97.4%
Groff	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Gulfcoast	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	98.2%	99.5%	94.1%	95.0%	95.9%	98.2%	94.1%	95.4%	96.3%
Henderson	84.0%	100.0%	64.0%	96.0%	96.0%	96.0%	88.0%	92.0%	92.0%
Holly	94.2%	99.7%	87.3%	94.0%	96.8%	91.8%	91.2%	91.3%	93.9%
Leifeste	97.6%	100.0%	88.0%	95.3%	98.6%	95.5%	95.9%	96.6%	96.4%
Murphy	98.7%	99.6%	95.7%	94.5%	95.3%	98.7%	95.3%	97.9%	94.5%
Qureshi	90.4%	100.0%	84.6%	96.2%	98.1%	90.4%	92.3%	94.2%	88.5%
Satterwhite	98.3%	100.0%	90.4%	90.4%	94.8%	99.1%	93.9%	93.0%	98.3%
Spiel	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	97.3%	99.7%	87.2%	93.9%	96.5%	95.5%	97.1%	95.2%	97.1%
Vardiman	96.9%	100.0%	88.8%	91.8%	96.9%	98.0%	93.9%	98.0%	95.9%
Young	86.8%	100.0%	73.6%	88.7%	86.8%	86.8%	86.8%	83.0%	86.8%
SETMA Totals :	96.4%	99.8%	89.1%	93.8%	96.4%	95.1%	93.7%	94.6%	95.4%

Care Transition Audit

Care Transition Audit (Section B)

Discharge Date(s): 01/01/2010 through 12/31/2010

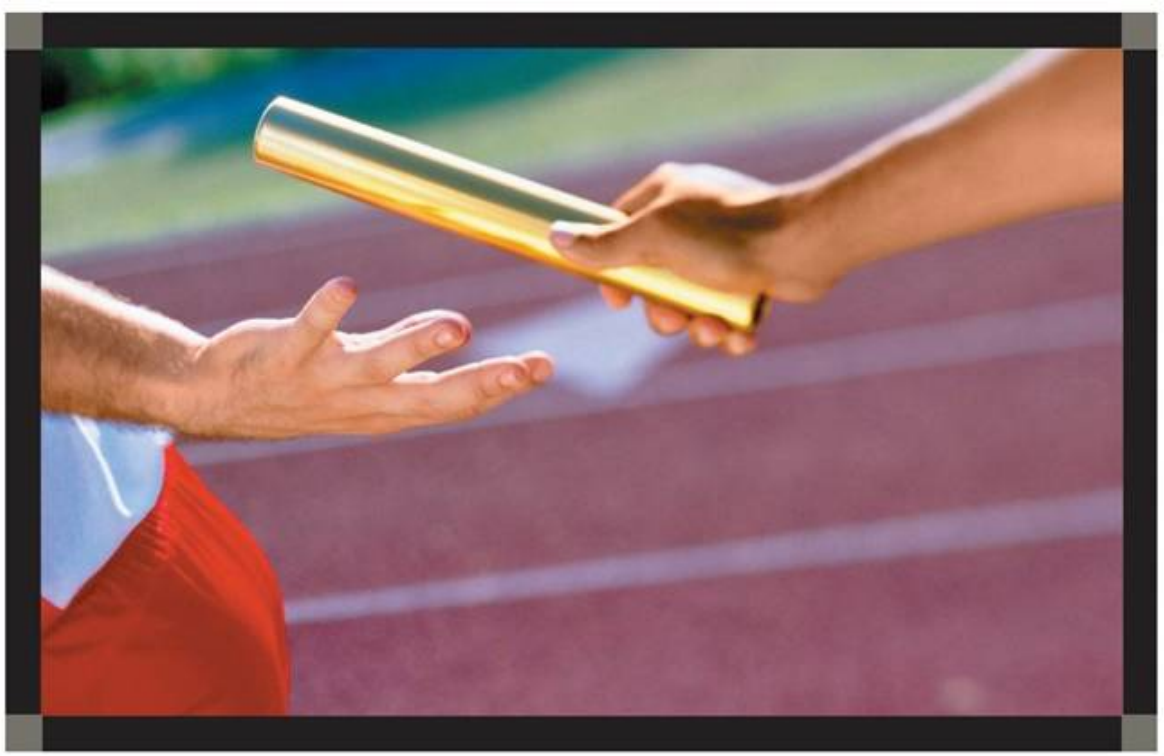
Provider	Advanced Directives	Reason for Discharge	Physical Status	Psychosocial Status	Community Resources Coordinated Referrals	Medication List	Discharge Orders	Follow-Up Instructions	Discharge Materials
Ahmed	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%
Anwar	76.1%	95.2%	94.5%	88.7%	68.5%	77.6%	78.3%	78.3%	78.1%
Aziz	88.5%	97.9%	97.2%	93.9%	33.8%	83.7%	83.7%	83.5%	83.2%
Colbert	50.0%	100.0%	83.3%	50.0%	33.3%	50.0%	50.0%	50.0%	50.0%
Cricchio	36.1%	91.7%	97.2%	86.1%	8.3%	86.1%	86.1%	86.1%	86.1%
Curry	88.7%	100.0%	96.2%	96.2%	48.1%	85.8%	85.8%	85.8%	85.8%
Deiparine	85.6%	97.4%	97.2%	93.7%	77.3%	84.7%	84.7%	84.7%	84.5%
Groff	66.7%	100.0%	100.0%	66.7%	66.7%	100.0%	100.0%	100.0%	100.0%
Gulfcoast	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	88.6%	98.2%	95.9%	93.6%	47.9%	81.3%	81.7%	81.7%	81.7%
Henderson	24.0%	92.0%	96.0%	92.0%	44.0%	56.0%	56.0%	56.0%	56.0%
Holly	81.8%	93.2%	97.3%	91.8%	76.9%	80.7%	80.8%	80.7%	80.6%
Leifeste	85.2%	96.4%	98.6%	93.1%	69.4%	84.4%	84.4%	84.4%	83.8%
Murphy	88.5%	97.9%	96.6%	95.7%	53.2%	87.2%	87.2%	87.2%	87.2%
Qureshi	84.6%	90.4%	98.1%	96.2%	76.9%	82.7%	82.7%	82.7%	82.7%
Satterwhite	69.6%	98.3%	95.7%	90.4%	43.5%	69.6%	69.6%	69.6%	68.7%
Spiel	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	84.8%	96.0%	97.1%	93.4%	73.4%	83.2%	83.5%	83.5%	83.2%
Vardiman	74.5%	98.0%	96.9%	91.8%	62.2%	79.6%	78.6%	78.6%	78.6%
Young	67.9%	83.0%	86.8%	84.9%	30.2%	69.8%	69.8%	69.8%	69.8%
SETMA Totals :	82.7%	95.8%	96.8%	92.5%	63.2%	81.8%	81.9%	81.9%	81.7%

Hospital Care Summary

Once the **Care Transition** issues are completed, The **Hospital Care-Summary-and-Post- Hospital-Plan-of Care-and Treatment-Plan** document is generated and printed. It is given to the patient and/or to the patient's family, and to the hospital.

The Baton

The following picture is a portrayal of the "plan of care and treatment plan" which is like the "baton" in a relay race.



The Baton

"The Baton" is the instrument through which responsibility for a patient's health care is transferred to the patient or family. Framed copies of this picture hang in the public areas of all SETMA clinics and a poster of it hangs in every examination room. The poster declares:

Firmly in the provider's hand
--The baton -- the care and treatment plan
Must be confidently and securely grasped by the patient,
If change is to make a difference
8,760 hours a year.

The Baton

The poster illustrates:

1. That the healthcare-team relationship, which exists between the patient and the healthcare provider, is key to the success of the outcome of quality healthcare.
2. That the plan of care and treatment plan, the “baton,” is the engine through which the knowledge and power of the healthcare team is transmitted and sustained.
3. That the means of transfer of the “baton,” which has been developed by the healthcare team, is a coordinated effort between the provider and the patient.

The Baton

4. That typically the healthcare provider knows and understands the patient's healthcare plan of care and the treatment plan, but without its transfer to the patient, the provider's knowledge is useless to the patient.

5. That the imperative for the plan – the "baton" – is that it must be transferred from the provider to the patient, **if change in the life of the patient is going to make a difference in the patient's health.**

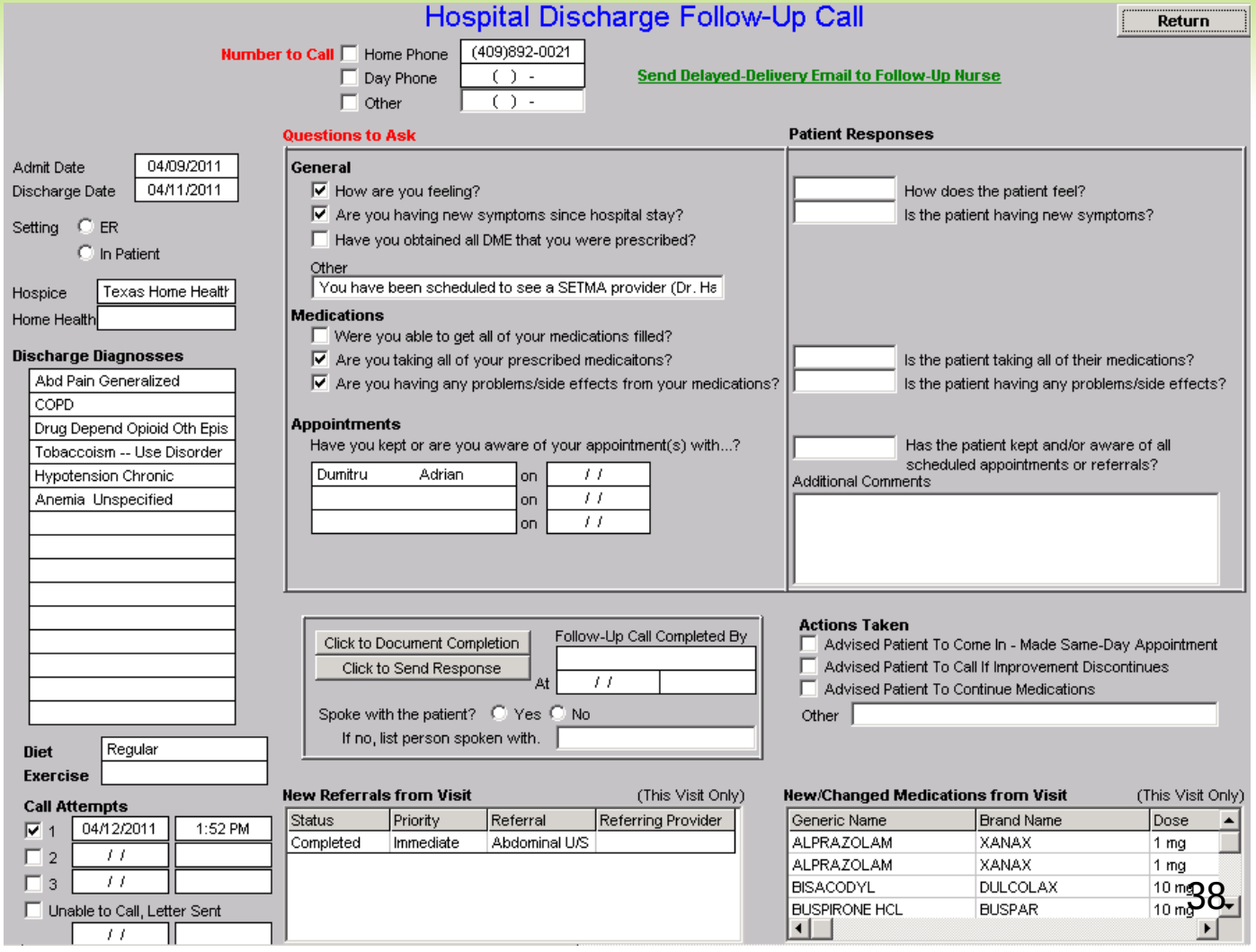
The Baton

6. That this transfer requires that the patient “grasps” the “baton,” i.e., that the patient **accepts**, **receives**, **understands** and **comprehends** the plan, and that the patient is equipped and empowered to carry out the plan successfully.

7. That the patient knows that of the 8,760 hours in the year, he/she will be responsible for “carrying the baton,” longer and better than any other member of the healthcare team.

Hospital Follow-Up Call

After the care transition audit is completed and the document is generated, the provider completes the Hospital-Follow-up-Call document:



Hospital Discharge Follow-Up Call

Return

Number to Call: Home Phone (409)892-0021; Day Phone ( ) -; Other ( ) -

Send Delayed-Delivery Email to Follow-Up Nurse

Admit Date 04/09/2011
Discharge Date 04/11/2011

Setting: ER / In Patient

Hospice: Texas Home Health
Home Health:

Discharge Diagnoses

- Abd Pain Generalized
- COPD
- Drug Depend Opioid Oth Epis
- Tobaccoism -- Use Disorder
- Hypotension Chronic
- Anemia Unspecified

Diet: Regular
Exercise:

Call Attempts

1	04/12/2011	1:52 PM
2	/ /	
3	/ /	

Unable to Call, Letter Sent / /

Questions to Ask

General
- How are you feeling?
- Are you having new symptoms since hospital stay?
- Have you obtained all DME that you were prescribed?

Other: You have been scheduled to see a SETMA provider (Dr. Ha

Medications
- Were you able to get all of your medications filled?
- Are you taking all of your prescribed medicaitons?
- Are you having any problems/side effects from your medications?

Appointments

Have you kept or are you aware of your appointment(s) with...?

Dumitru	Adrian	on / /
		on / /
		on / /

Patient Responses

- How does the patient feel?
- Is the patient having new symptoms?
- Is the patient taking all of their medications?
- Is the patient having any problems/side effects?
- Has the patient kept and/or aware of all scheduled appointments or referrals?

Additional Comments

Click to Document Completion
Click to Send Response

Follow-Up Call Completed By
At / /

Spoke with the patient? Yes / No
If no, list person spoken with.

Actions Taken
- Advised Patient To Come In - Made Same-Day Appointment
- Advised Patient To Call If Improvement Discontinues
- Advised Patient To Continue Medications

Other

New Referrals from Visit (This Visit Only)

Status	Priority	Referral	Referring Provider
Completed	Immediate	Abdominal U/S	

New/Changed Medications from Visit (This Visit Only)

Generic Name	Brand Name	Dose
ALPRAZOLAM	XANAX	1 mg
ALPRAZOLAM	XANAX	1 mg
BISACODYL	DULCOLAX	10 mg
BUSPIRONE HCL	BUSPAR	10 mg

Follow-Up Call -- I

- During that preparation of the “baton,” the provider checks off the questions which are to be asked the patient in the follow-up call.
- The call order is sent to the Care Coordination Department electronically. The day following discharge, the patient is called.
- The call is the beginning of the “**coaching**” of the patient to help make them successful in the transition from the inpatient setting.

Follow-Up Call – II

- The Care-Coordination, post-hospital call takes 12-30 minutes with each patient and engages the patient in eliminating barriers to care.
- If appropriate, an additional call is scheduled at an appropriate interval.
- If after three attempts, the patient is not reached by phone, the box in the lower left-hand corner by "Unable to Call, Letter sent" is checked. Automatically, a letter is created which is sent to the patient asking them to contact SETMA.

Coordinated Care

The genius and the promise of the Patient-Centered Medical Home are symbolized by the "baton." Its display continually reminds the provider and will inform the patient, that to be successful, the patient's care must be **coordinated**, and must result in **coordinated care**.

In 2011, as we expand the scope of SETMA's Department of Care Coordination, we know that the principal failure-points of coordination are at the "transitions of care," and that the work of the healthcare team – patient and provider – is that together they evaluate, define and execute a plan which is effectively transmitted to the patient.

Transition of Care

The complexity of the Transition of Care process is illustrated by this analysis of the eight different places this document can need to be sent.

Hospital Care Summary

1. **Inpatient to ambulatory outpatient** (family) – The "baton," in a printed format, is given to the patient or in the case of a minor or incompetent adult to a parent or care giver.

   The "plan of care and treatment plan" -- "the baton" -- is reviewed with the patient, parent and/or family before the patient leaves the hospital.

Hospital Care Summary

2. **Inpatient to ambulatory outpatient** (clinic physician) – for patients who are seen at SETMA, the "baton" is created in the EHR and is immediately accessible to the follow-up provider.

Hospital Care Summary

3. **Inpatient to ambulatory outpatient** (follow-up call) -- after the **Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan** is completed, a secure e-mail is sent to the department of Care Coordination scheduling the post-hospital, follow-up call and letting the caller know the issues which need to be addressed.

Hospital Care Summary

4. **Emergency Department to ambulatory care** – the same process as in "1" above.
5. **Inpatient to Nursing Home** -- the "baton," with a special set of Nursing Home orders, is given to the patient or family, and a copy is sent to the Nursing Home with transportation of the patient to the Nursing home.
6. **Inpatient to Hospice** -- the same as with number “5“
7. **Inpatient to Home Health** -- the same as number "5“ and "6" above. If the patient is seeing SETMA's home health, they have access to SETMA EHR and thus to the "baton."

Hospital Care Summary

8. **Inpatient to outpatient out of area** -- "Baton" given to patient and family and also posted to web portal and HIE. token sent to health provider in remote location area, which allows one time access to this patient's information.

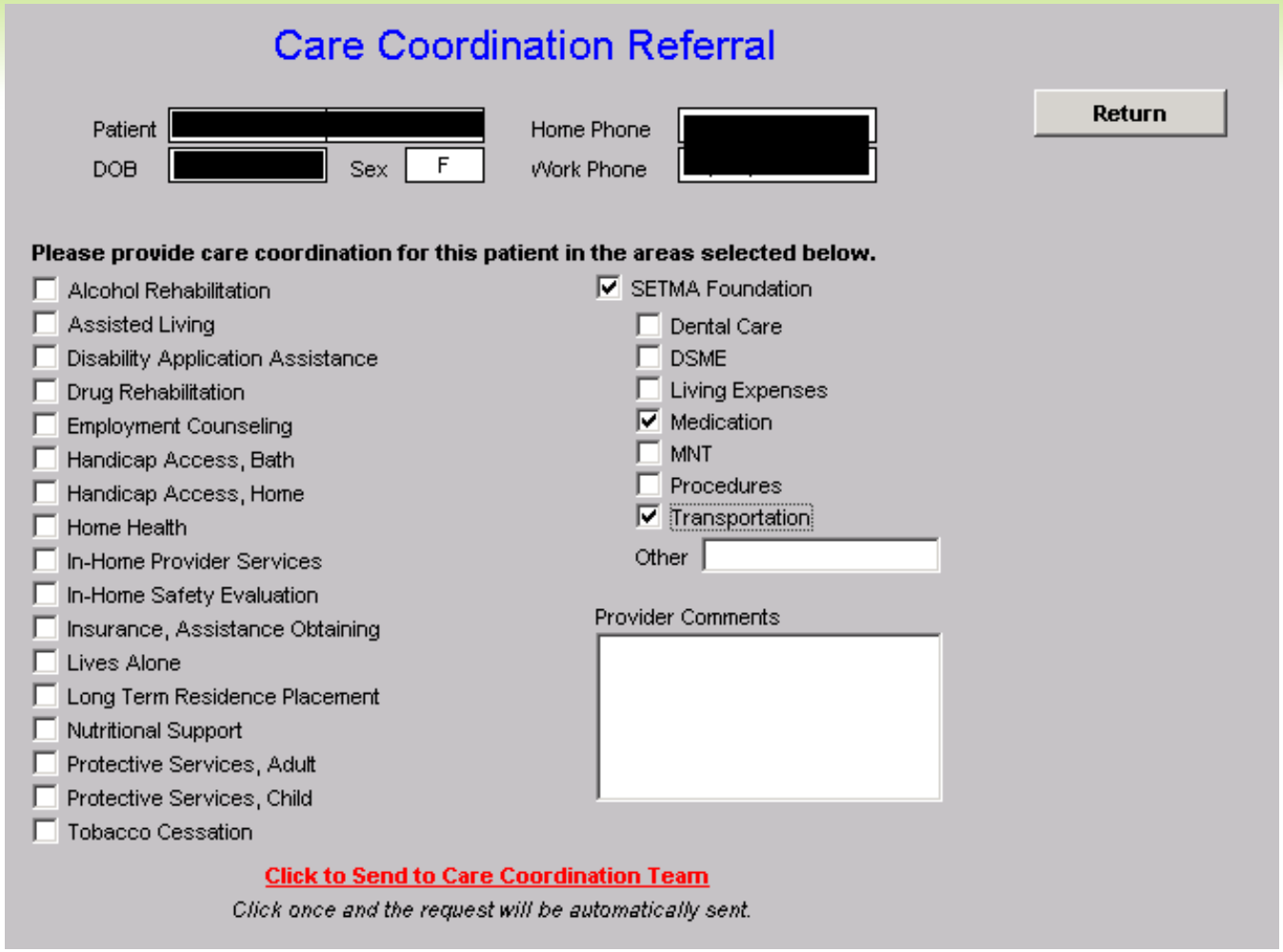
Follow-Up Visit

The Transition of Care is complete when the patent is seen by the primary care provider in follow-up.

- Many issues are dealt with in this follow-up visit, but one of them is another potential referral to the Care Coordination Department. If the patient has any barriers to care, the provider will complete the following template.

- In this case, with checking three buttons, the need for financial assistance with medications and transportation is communicated to the Care Coordination Department.

Care Coordination Referral



SETMA Foundation

Under the Medical Home model the provider has NOT done his/her job when he/she simply prescribes the care which meets national standards. **Doing the job of Medical Home requires the prescribing of the best care which is available and accessible to the patient, and when that care is less than the best, the provider makes every attempt to find resources to help that patient obtain the care needed**.

SETMA Foundation

In February 2009, SETMA saw a patient who has a very complex healthcare situation. When seen in the hospital as a new patient, he was angry, bitter and hostile. No amount of cajoling would change the patient's demeanor.

During his office-based, hospital follow-up, it was discovered that the patient was only taking four of nine medications because of expense; could not afford gas to come to the doctor; was going blind but did not have the money to see an eye specialist; could not afford the co-pays for diabetes education and could not work but did not know how to apply for disability.

SETMA Foundation

He left SETMA with the Foundation providing:

1. All of his medications. The Foundation has continued to do so for the past two years at a cost of $2,200 a quarter.
2. A gas card so that he could afford to come to multiple visits for education and other health needs.
3. Waiver of cost for diabetes education in SETMA's American Diabetes Association accredited Diabetes Self Education and Medical Nutrition Therapy program.
4. Appointment to an experimental, vision-preservation program at no cost.
5. Assistance with applying for disability.

SETMA Foundation

Are gas cards, disability applications, paying for medications a part of a physician's responsibilities? Absolutely not; but, are they a part of Medical Home? Absolutely! This patient, who was depressed and glum in the hospital, such that no one wanted to go into the patient's room, left the office with help.

He returned six-weeks later. He had a smile and he had **hope**. It may be that the biggest result of Medical Home is hope. And, his diabetes was treated to goal for the first time in ten years. He has remained treated to goal for the past two years.

SETMA Foundation

Every healthcare provider doesn't have a foundation and even ours can't meet everyone's needs, but assisting patients in finding the resources to support their health is a part of medical home.

SETMA Foundation

And, when those resources cannot be found, Medical Home will be “done” by modifying the treatment plan so that what is prescribed can be obtained.

The ordering of tests, treatments, prescriptions which we know our patients cannot obtain is not healthcare, even if the plan of care is up to national standards.

Hospital Care Summary

- With this infrastructure
- With this care coordination
- With this continuity of care
- With these patient support functions

SETMA is ready to make a major effort to decrease preventable readmissions to the hospital.

Care Transitions & Hospital Readmissions

With this vision, SETMA expects to significantly affect hospital preventable re-admission rates over the next two years and to sustain those improvements.

Supported by care transitions, coordination of care, medication reconciliation (at multiple points of care) patient safety, quality of care and cost of care will be positively impacted.