James L. Holly, M.D.

Care Transitions

Generic information given to the patient, which is not personalized and/or which does not contain the patient's personal health information will usually be ignored. But, when the patient is given educational materials or instructions with their name on it and with their data in it, they will pour over it. This is why the structure of "care coordination" requires that the information given to a patient have the patient's name on it and that it includes the patient's personal information. One of the most teachable moments in medicine occurs when the patient returns to a follow-up visit, and with the previously given "plan of care' and "treatment plan" in hand, declares, "This information is wrong!" At this point, the patient is engaged and ready to learn. This statement does not glorify error, if error exists, but it does focus on the value of patient realization that their “reality” appears to them to be unreal.

The more important information is, the more probable it is that a person will forget that information, remember it incompletely, or be confused by it. This is particularly the case when the information is complex, containing unfamiliar terms and spoken to the patient only once and briefly.

It is at this "transitions of care" - when the patient leaves the point of care, which most often is the healthcare provider's office-- where "care coordination" is most critical. As a result, a poster now appears in all of SETMA's examination rooms and in strategic points around the clinic. It is called "The Baton," and it illustrates the necessity for the healthcare provider to "hand off" "the baton" to the next member of the team - the patient -- who is to carry the team's plans and purposes to the goal - improved or sustained health.

The following appears on the "Baton" poster:

"The baton" is a metaphor for the "plan of care' and a "treatment plan" which informs and empowers the patient to assume responsibility for his/her own care. In this context, the term "grasp" is apt, as the word refers both to physical and mental acts. The patient must not only receive "the baton' in the hand physically (grasp it), but must also comprehend the content of the "baton" mentally - "lay hold of it with the mind." If the patient "grasps" - understands, comprehends -- the "plan of care" and the "treatment plan," i.e., "the baton," and if the patient accepts - agrees to it and determines to carry it out -- the "patient/provider complex" is formed, completing the team and maximizing the opportunity for the team's success.

The patient/provider complex" is the essential element of success for effective healthcare action to be taken; particularly in the ambulatory setting. Without the formation of this element, at

best the process will be incomplete and the outcome will only be partially successful. The "baton" is the key "care coordination" document which is the core of "care transitions."

Medical Home Transitions of Care: One Form of Care Coordination

- Transition of Care - One form of Care Coordination

    1. Care Transitions - the Heart of PC-MH
    2. Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan
    3. Changing the name to clarify the function
    4. Medical Home Plan of Care and Treatment Plan
    5. Passing the Baton
    6. Summary of Care Transitions
    7. Care Transitions Data Set from PCPI
    8. Transitions of Care Management Codling
    9. Transitions of Care To Reduce Preventable Readmissions
    10. Improving SETMA Care Transitions and Care Coordination

- HiMSS-2012 Care Transitions: The Heart of Patient-Center Medical Home

    Analyze the process of a desired outcome by designing and deploying an IT solution to support Care Transitions from inpatient hospital to ambulatory care; Demonstrate how IT solutions can aide in dealing with barriers to care in the transition from hospital to ambulatory care; Demonstrate the place of care coordination in Care Transitions; Demonstrate the place of auditing of performance in sustaining effective care transitions; Demonstrate the place of a healthcare delivery team in an IT solution to care transitions.

- HIMSS 2012: Leaders and Innovators Breakfast Meeting

    Innovators Breakfast -- Convenience is the New Word for Quality

- SETMA's video submitted to the Robert Wood Johnson Foundation's Video Contest

    November, 2012 -- The Institute for Healthcare Improvement's Triple Aim is to improve care, improve health and decrease cost. A difficult problem in healthcare is the frequency of 30-day readmission to the hospital. Often the cause for readmission are related to medication problems and to poor care transitions. SETMA has designed a care transition program which combines the forces of a hospital care team with informatics and care coordination to: -- A two minute video presentation of SETMA's Transition of Care is accessible through this link.

- A Care System for Effecting Reductions in Preventable Readmission Rates

  April, 2012 - News Letter from Readmissions News features SETMA Transition of Care program.

- SETMA and the National Quality Forum

  NQF responded with the following invitation: "Thank you as well for sending along this useful and encouraging information on care coordination. I see you have registered as part of our audience, which is an open invitation extended to all NQF members. Allow me to offer you a formal initiation to attend the workshop as an invited content expert in this field and to participate in the round table discussions we will be having. Assuming this is agreeable we will send you along additional logistics." During that conference, it became apparent that one fundamental flaw in healthcare is the name used for the hospital summary of care It is currently called a "discharge summary," and is essentially an administrative document required to complete the patient's record. However, when seen in its "real" purpose, this document would better be entitled, "Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan." SETMA has made that name change and is benefiting from the new and clearer understanding of the rationale for this document.

- Patient-Centered Medical Home and Care Transitions: Part I

  April, 2011 -- We immediately changed the name of that document to "**Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan**." This is a long and perhaps awkward name, but it is extremely functional, focusing on the unique elements of Care Transition. From June, 2009 to April, 2011, SETMA has a 99.1% rate of completing this document at the time the patient leaves the hospital. During this time we have discharged 6,147 patients from the hospital.

- Patient-Centered Medical Home and Care Transitions: Part II

  "The Baton" is a portrayal of the "plan of care and treatment plan" which is like the "baton" in a relay race. It 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 providers 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.

- Passing the Baton: Effective Transitions in Healthcare Delivery

  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.

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

  January, 2013 --- SETMA's team approach to inpatient care is a success as demonstrated by the facts that our lengths of stay, quality metrics, cost of care and patient satisfaction are excellent. And, it is one of the reasons why the indigent, uninsured and unassigned patients for whom we care receive the same quality of care as our private patients. I would offer the following observations about SETMA's team. SETMA has licensed and credentialed healthcare professionals who work to the top of, but not beyond their legal scope of practice as defined by each of their accreditation agencies.. As a policy issue, the prestigious and influential *Health Affairs* publication of January 14, 2013, published an extensive article entitled, *Primary Care Physician Shortages Could Be Eliminated Through Use Of Teams, Non-physicians, And Electronic Communication*" The goal of this transformation is the integrate the teams to increase their efficiency, excellence and economy This is what SETMA started eighteen years ago.

- Reducing Preventable Readmissions to the Hospital

  July, 2012 Study on Readmissions and their Prevention

- Medical Home Series Two: Part VI Care Transitions

  One of the principle elements of continuity of care is effective "transitions of care." There are few places where the ideals of Patient-Center Medical Home (PC-MH) are as clearly needed and as clearly seen as in the "transitions of care" from one setting of care to another, such as: Hospital inpatient to Ambulatory Outpatient; Ambulatory outpatient clinic to ambulatory outpatient home; Hospital inpatient to long-term, residential care (Nursing Home); One provider to another.

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

  During the CMMI Summit, Dr. Holly responded to some of the presentations. In the introduction to the conference, reference was made to the participants. Repeatedly, the names of companies who make products were mentioned. Dr. Holly's comment was: "....(he) discussed "companies," "companies," "companies!!!" Companies **WILL NOT**, companies **CANNOT**, transform healthcare. Providers and Patients **WILL** make this transformation happen!!! "Healthcare reform can be top down and with enough pressure and regulation, reform can bring temporary change, but sustainable, permanent, self-perpetuating change requires transformation. Transformation comes from internalized values and personal passion, which operates independent of reform and which will in fact find reform slow, ponderous and inadequate. "Real change will

require a dynamic partnership between government, private companies, academics and practicing healthcare providers. To imagine success while functionally ignoring the last group will result in either failure or at best partial success. “Top down will not work. Collaboration, dynamic partnership, between all four groups will get us where we want to be and it will keep us there. The best which reform demands cannot match what transformation will produce.”

- The Future of Healthcare - SETMA's View

  In 1949, George Orwell wrote a book entitled *1984*, which year came and went. In the year 1984, the movie *2010* was released and now we approach that year. More of the science fiction of the latter movie has become reality in the intervening 25 years than have the dire predictions of Orwell in his 60-year-old prophesy. As we approach the beginning of the second decade of what only recently was a new century, I pause to think about the past and the future. In 2010, SETMA will celebrate fifteen years since its founding. Only one of the founding partners’ remains and sadly in March of the New Year, we will experience the one-year anniversary since the death of our dear friend and colleague, Mark A. Wilson.