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Hospital Care Tools

Through SETMA's deployment of our ambulatory care EMR, and with the collaboration of SETMA's Hospital Care Team, we have been completing hospital history and physical examinations, discharged summaries (renamed "Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan in September, 2010) in the EMR for over twelve years. We have the capacity to complete daily progress notes in the EMR, also. The tools for excellent performance in the hospital are described below.

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

Nomenclature Can Confuse Function

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 Function

In September, 2010, SETMA representatives as an invited participate attended a National Quality Forum conference on Transitions of Care. (NQF - Summary of Dr. Holly's Comments - September 2nd, 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.” The purpose and content of the new document was defined as:

- Physician Consortium for Performance Improvement Care Transition Data Set 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.

- 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. Those will be discussed later.

  SETMA has been tracking and auditing the Physician Performance for Performance Improvement Transitions of Care Quality Metrics since they were published in 2009. By provider name, those metrics are published at www.jameslhollymd.com under Public Reporting for 2009, 2010, 2011, 2012. In the past 36 months, SETMA has discharged over 14, 000 patients from the hospital. 98.7% of the time patients have received their Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan (previously called “Discharge Summary “when they left the hospital. Since 2010, SETMA’s Care Coordination Department has also been involved in the transitions process.

It is only logical that SETMA would be prepared to utilize the new Transitions of Care Codes. At this time, there is only one unresolved issue related to using these codes. Neither CMS nor the Medicare State Contractors are willing to clarify that issue. In order to determine which of the Transitions of Care Management Codes to use, the healthcare provider must distinguish between a Moderately Complexity visit and a High Complexity visit. This tutorial assumes that the complexity discriminator refers to the E&M codes for 99214 and 99215, in which case it would generally be possible for a provider only to use the lower of the TCM codes, i.e., 99495. Others argue that the terms "moderate" and "high" complexity are not defined by the E&M code descriptions and if they are, the correct reference would be 99213 and 99214. That seems unreasonable as in that case, the higher TCM Code, i.e., 99496 would be the most commonly used TCM Code. Until this is officially clarified, SETMA is going to assume that the terminology refers to 99214 and 99215. This will cause us to use a lower code than may be valid, but at least it will not result in fraud and abuse charges.

SETMA's Tools for the Transitions of Care Management Codes (TCM Codes)

When a patient is seen at SETMA who has been discharged from the hospital or another in-patient setting, a note automatically appears on the AAA Home Template, indicating that the patient is eligible for a Transitions of Care Management evaluation. If the patient is not eligible, then that space will be blank. This alert is illustrated below outlined in green.

- Using The Clinic and Hospital Follow-up Call Templates

  As part of patient-centric care, SETMA's Care Coordination Department staff places care coaching calls to selected patients seen in the clinic and to all patients who have been discharged from the hospital or from the emergency department.

- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): Tutorial for SETMA's Internal HCAHPS Survey

  Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a structured set of standards by which to measure healthcare provider and hospital performance. SETMA has long had the philosophy that if healthcare providers are going to be held accountable for certain actions, they ought to: Know what they are going to be held accountable for; Measure their performance before an external organization reports this performance at some distant time in the future; Have a plan and a method for improving their performance. In August, 2014, SETMA designed a system by which SETMA's Care Coordination department in the Care Coaching Call the day following discharge from the hospital, SETMA could assess our own HCAHPS performance. While this will not be accepted as THE official score, it does involve SETMA providers in the fulfillment of these standards. Below this tutorial is a lengthy discussion of SETMA's 8-day pilgrimage to excellence in HCAHPS performance as a

function of patient-centeredness in inpatient care. This is the beginning of our becoming patient-centered in our inpatient care...

- Admission Orders Tutorial

  The transition from the outpatient to the inpatient setting is important. It is critical to initiate care in the inpatient setting as quickly as possible. With predetermined order sets, it is possible for any provider regardless of personal experience or knowledge to generate a disease-specific order set designed by a specialist. Using SETMA's Admission Order sets, it is possible for excellent care to be started without delay.

- Hospital Daily Progress Note Tutorial

  The **Hospital Daily Progress Note** templates enable an inpatient-hospital note to be completed efficiently and excellently with data being accumulated over the course of an inpatient stay. This data is then automatically aggregated for the Discharge Summary to be completed quickly and completely. The complexity of this task will become obvious as you review this tutorial. However, the use of the Hospital Daily Progress Note is very much easier than it may seem from the length of this tutorial. Of necessity, the variety of documentation needs for inpatient, daily progress notes is such that the suite of templates will be large, but applied to individual patients, they are manageable and valuable. In addition, the Hospital Daily Progress Note is the "last piece" in making a patient's care seamless regardless of where the patient is being treated. The inpatient record is not isolated in a patient's hospital chart but through the hospital daily progress note has become a dynamic part of the patient's medical record and contributes to the continuity of care and to the continued building of a detailed, accurate and complete portrait of the patient's health history, condition, care and needs.

- Care Transitions Data Set from Physician Consortium for Performance Improvement

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