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Medical Home – Series Two Part VI Care Transitions
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While this is titled *Series Two on Medical Home*, the first being eleven articles long and beginning in February, 2009, this is actually the third series. The second started July 29, 2010 and ran through September, 2010. It is entitled, "A New Day in Healthcare for you and for us." Along with occasional individual pieces on medical home, SETMA's documentation of our growing understanding of and experience with Patient-Centered Medical Home now exceeds fifty articles posted on www.jameslhollymd.com at *Your Life Your Health* under the icon entitled *Medical Home*.

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:

1. Hospital inpatient to Ambulatory Outpatient.
2. Ambulatory outpatient clinic to ambulatory outpatient home
3. Hospital inpatient to long-term, residential care (Nursing Home)
4. One provider to another

It is at these points where the quality of care is most often diminished, or even lost. It is by examining these points that the "organizational domain" of the future of healthcare can be transformed.

In SETMA's Model of Care (for a full description of this model see SETMA's presentation to the Federal Government's Office of National Coordinator (HIT, HHS) at the following link: The Future of Healthcare), Care Transitions involves:

- Fulfillment of the Physician Collaborative for Performance Improvement (PCPI) Transitions of Care Quality Metric Set which has fourteen data points and four action items.
- Post Hospital Follow-up Call which is a 12-30 minute call which takes place the day after the patient leaves the hospital which is made by members of SETMA's Care Coordination Department.
- Plan of Care and Treatment Plan, which is symbolized by the "baton."
- Follow-up visit with primary provider in less than seven days of discharge and usually within three.

Over the past fourteen years, SETMA has developed numerous tools, (follow this link for a review of this history Care Transitions) which enables us to do "medical home," to address each element of the transitions of care listed above, and to sustain an effort to impact hospital preventable readmission rates.

Transitions of Care Quality Metrics Set

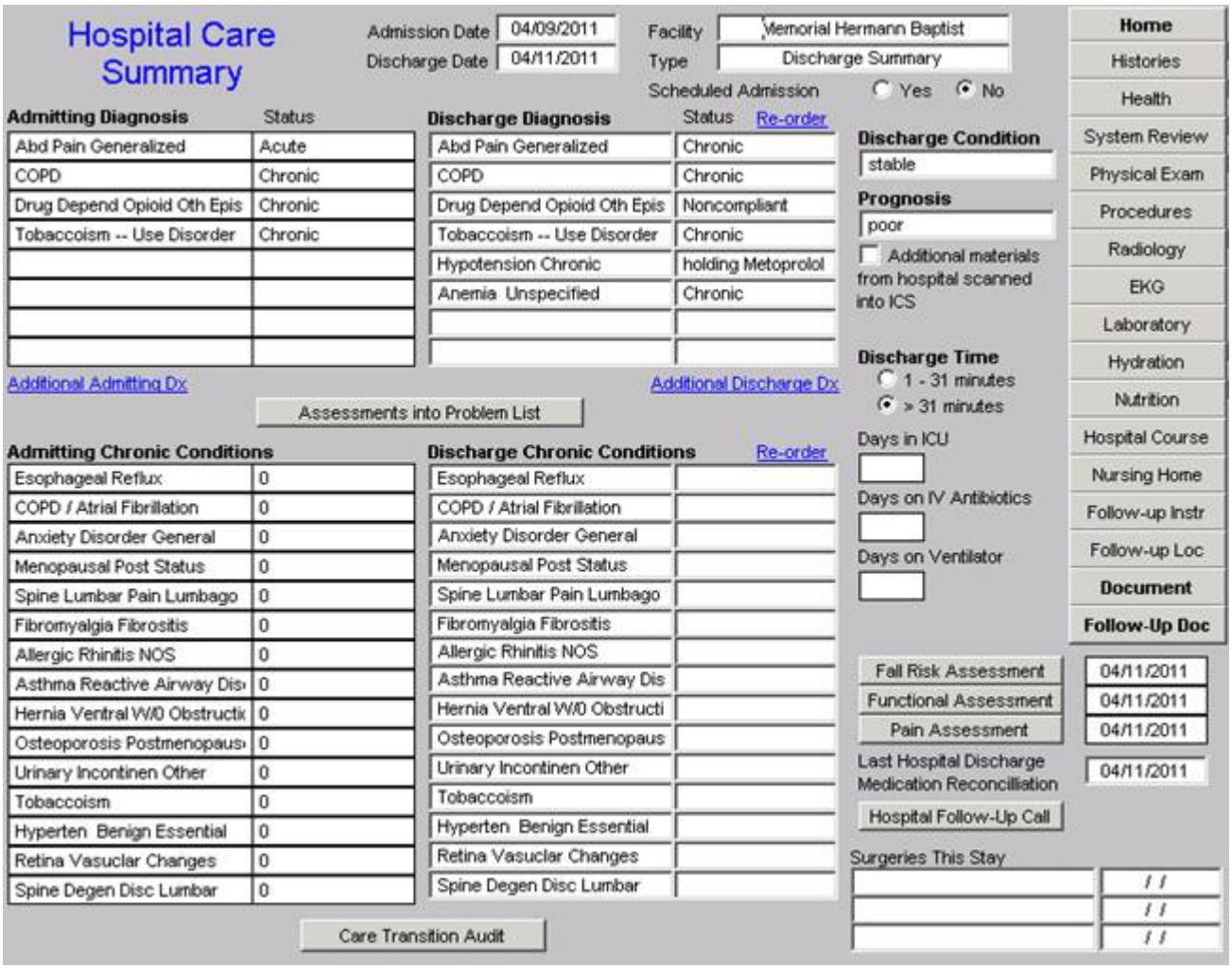
In June, 2009, the Physician Consortium for Performance Improvement (PCPI) of the American Medical Association published a quality metric set on Transitions of Care which involved 14 data points and 4 actions. Because SETMA had been completing hospital history and physicals and discharge summaries in the EHR for ten years, we were prepared to deploy this measurement set. Since July, 2009 we have successfully completed the measurement set on over 7,000 patients discharged from the hospital.

After a fifteen-month experience with Transitions-of-Care quality metrics set, in September, 2010 members of SETMA's team attended the National Quality Forum workshop on Care Transitions in Washington. During that conference, it occurred to SETMA that the name "discharge summary" for the hospital-care summary was outdated and not helpful. The document had become almost an administrative function, often completed weeks after the patient left the hospital. It was not the critical element in the patient's moving from their inpatient or emergency department care to the ambulatory or other setting. The document had little function in transitions of care and was not a functional part of the medical-home model-of-care.

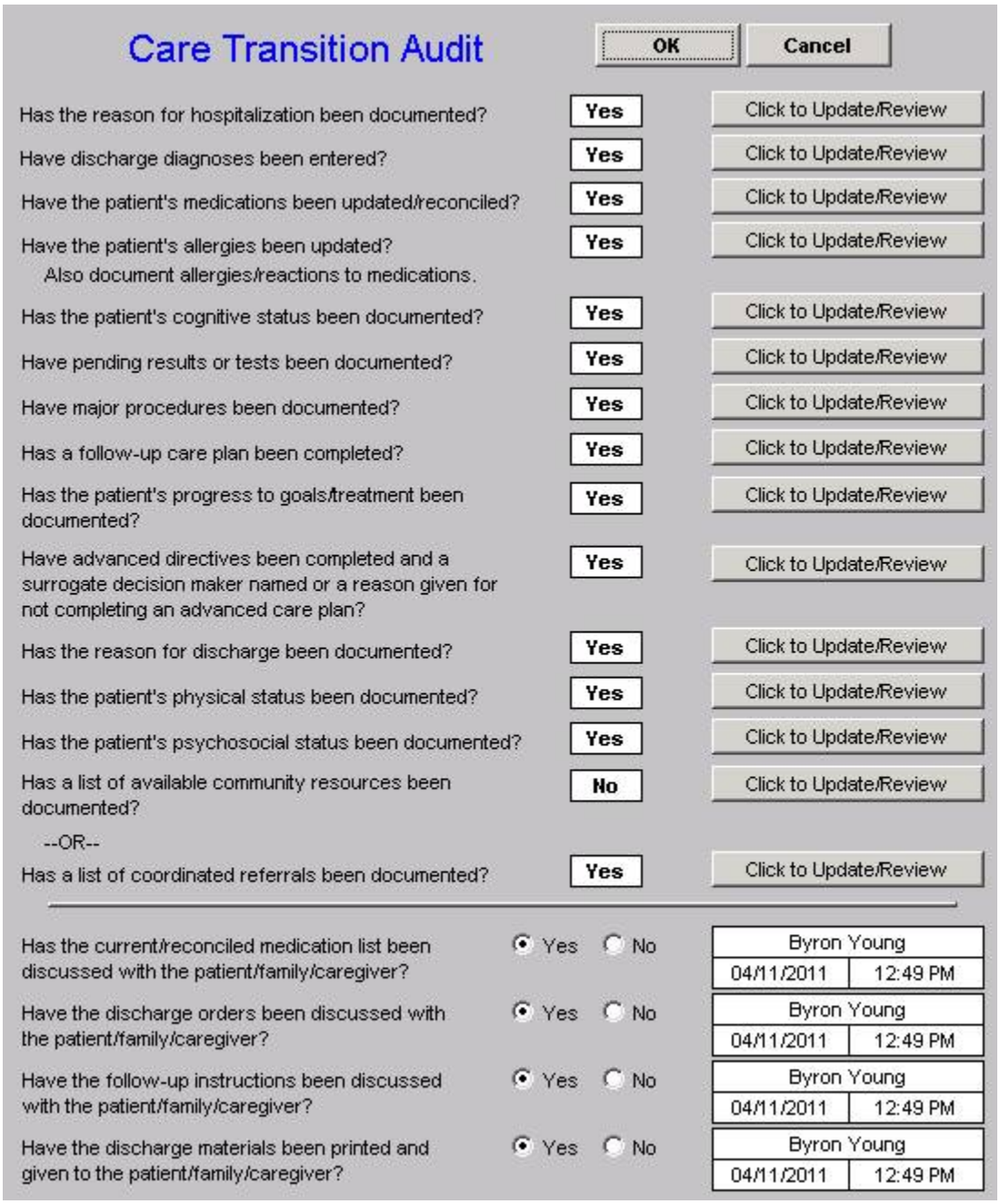
SETMA immediately changed the name to "**Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan**." This is a long and perhaps awkward name, but it is extremely functional, focusing on the unique elements of Care Transition. It also fulfills the medical home need for preparing the patient to care for him/her self, for medication reconciliation and for having a written plan of care and treatment plan which is given to the patient at the time of their leaving the hospital. From June, 2009 to August, 2011, SETMA has a 99.1% rate of completing this document at the time the patient leaves the hospital. As noted above, during this time we have discharged over 7,000 patients from the hospital.

Hospital Care Summary

SETMA saw these care-transition steps as part of our transformation into a medical home because the Hospital Care Summary is actually a suite of templates with which the care-summary document is created. (For a full description of this see the following on SETMA's website: **Electronic Patient Tools**; **Hospital Care Tools**; **Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan Tutorial**) 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.



At the bottom of this template there is a button entitled, "**Care Transitions Audit**." Once the templates associated with the Hospital Care Summary have 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. 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**." Instantly, the place where the missing information can then be added appears and the measure can be fulfilled. 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**."

At appropriate intervals, usually 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. This reporting is done by provider name. The following is the care transition audit results by provider name for

2010. This presently is posted on our website. The audit is done through SETMA's COGNOS Project which is described in detail on our website under **Your Life Your Health** by clicking on the icon entitled **COGNOS**

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%

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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%
Delparine	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%

The public reporting of quality metrics goes beyond the requirements of any medical home requirement which only requires the ability to report and to report to an external agency on 10 quality metrics.

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 to the hospital. The complexity of Transitions of Care is illustrated by this analysis of how many different places this document can be needed. It can go from:

- 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.
- Inpatient to ambulatory outpatient (clinic physician) -- for patients who are seen at SETMA, the "the baton" is created in the EHR and is immediately accessible to the follow-up SETMA provider. The provider is alerted by appointment when he/she is to see the patient and that the "baton" is available for review.
- Inpatient to ambulatory outpatient (follow-up call) -- after the Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan (HCSPHPCTP) is completed, a template is completed and sent to the Department of Care Coordination. This template is in the EHR where the HCSPHPCTP also resides. Both are immediately accessible to the

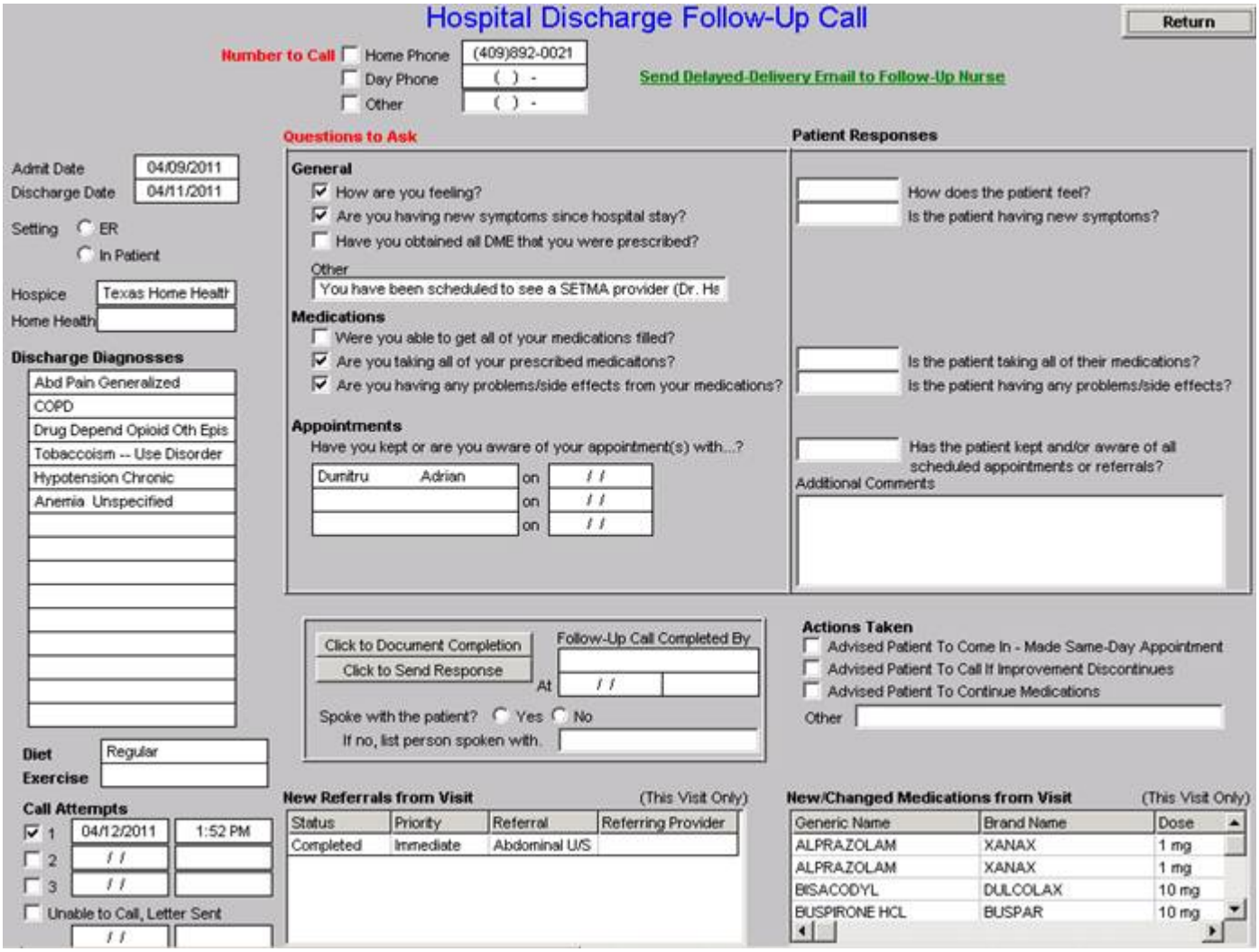
Department. The "follow-up call from the hospital" call request is delayed for one day so that the call is made the day after the patient leaves the hospital.

- Emergency Department to ambulatory care -- the same process as in "1" above.
- 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 the transportation to the Nursing home.
- Inpatient to Hospice -- the same as with number "6"
- 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."
- 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 area which allows one time access to this patient's information.

With this infrastructure and with this care coordination, continuity of care and patient support functions, SETMA is ready to make a major effort to decrease preventable readmissions to the hospital. The document generated once the care transition issues are met in part includes reconciled medications, follow-up appointments with time, dates, address and provider name and any referrals which have been initiated as a result of the hospitalization.

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:



During that preparation, 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. This call is a beginning of the "coaching" of the patient to help make them successful in the transition from the inpatient setting to their next level of care. After the call is completed, the answers to the questions are sent back to the primary care provider by the care coordinator. If the patient has any unresolved issues or is having any problem, he/she is given an appointment that same day.

The Care Coordination call takes 12-30 minutes with each patient and engages the patient in eliminating barriers to care. Recently, a complex case took one hour and twenty minutes but all transitions of care issues were successfully fulfilled avoiding the risk of readmission and losing the care plan which had been established at the time of discharge. 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.

Follow-up Visit with Primary Care Provider

The Transition of Care is complete only 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 Care Coordination template. It takes three clicks and the Department will work with the patient to meet their healthcare needs.

Care Transition is the heart of the continuity of care 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:

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