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SETMA's Care Coordination and Transitions of Care: Part I
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In anticipation of the Robert Wood Johnson Foundation's visit to SETMA October 29-November 1, 2012, I would like to describe SETMA's work in coordinating care between inpatient hospital care, outpatient ambulatory, clinic care, long-term residential care, and SETMA's care coordination department activities. SETMA has five identified teams in this collaboration:

1. Inpatient Hospital Care
2. I-Care – Long Term Residential Care
3. Care Coordination Department
4. Clinic Care Team
5. Ambulatory Care Team

The Inpatient Hospital Care Team is made of thirteen people dedicated to inpatient hospital care. Along with a team of sixteen attending physicians, the inpatient care of SETMA's patients is covered with a SETMA representative in the hospital 24-hours-a-day, seven days a week. This team was organized to promote improved quality of care for all of SETMA's patients and to promote improved quality of life for all SETMA healthcare providers. Because of the volume of patients SETMA sees in the hospital, in the clinic and in nursing home, the work load would be overwhelming without an organized team approach.

Continuity-of-Care

SETMA adopted the use of Electronic Health Records (EHR) in 1998. Over several years, we began using the EHR not only in the clinic but in the nursing home and in the hospital. Thus, wherever a patient is seen, their encounter is documented in the same data base. Thus, when the medication reconciliation is completed in the long-term residential facility (nursing home), it is simultaneously displayed in the same data base in which the patent's hospital admission history and physical is completed and/or the emergency department visit is documented. When a patient is seen in the clinic, after a hospital visit, the medication reconciliations, which was done upon admission to the hospital and repeated upon discharge from the hospital, is completed in the same data base which is used to document the outpatient-ambulatory-care visit. The same is true for a follow-up visit in the nursing home after a hospitalization.

In addition, laboratory evaluation and other procedures and tests are documented in the same data base no matter where the patient is seen. Thus, when a hemoglobin A1c is done in the nursing home, hospital, or clinic, it is visible to all providers at all locations. This decreases redundancy of testing and increases provider compliance with process quality metrics.

It is for this reason that SETMA has come to believe that while a personal relationship with a healthcare provider is valuable, ultimately the ideal of continuity-of-care is maintained by the EHR being available at every point-of-care and that the care at all points of care is documented in the same data base. The personal relationship is important to provider and patient, but patient safety and the goals of the Triple Aim (improved processes, improved outcomes and sustainability or lower cost) are supported more by the common data base than by the personality of the provider.

From Nursing Home or Ambulatory Care Setting to Inpatient Hospital

When a SETMA patient presents to the emergency department, or to the admissions office at a hospital, a member of SETMA's hospital care team will see the patient. That team member is either an RN or a CFNP. An initial evaluation is done and a record is completed. There is always a SETMA physician on call for the hospital. The hospital-care team communicates with the physician either by secure e-mail, or cell phone. If the patient's condition is critical, the on-call physician, or another SETMA physician in the hospital, will see the patient immediately. If the patent is not critical, the patient will be seen on morning, noon, or after-clinic rounds.

Hospital Care Team

The following in-patient documents are completed in the EHR:

1. Admission history and physical examination (H&P) – the hospital-care team prepares the documentation, it is approved by the physician and then is placed on the inpatient chart.
2. Inpatient Plan of Care and Treatment Plan – this is given to the patient and/or family at the time of admission. This document includes the reasons why the patient is in the hospital, how to communicate with the patient's healthcare provider and/or the hospital care team, a reconciled medical list, an estimate length of stay, consultants and procedures planned and the estimated risk of readmission upon discharge.
3. Reconciled Medical List – this is part of the admission H&P. A copy is given to the patient upon admission and upon discharge.
4. Order Sets – Standardized, vetted order sets for common and important conditions are created in the EHR so that no matter who completes the H&P, the care is the same.
5. **The Inpatient Medical Record Census** (IMRC) is the centralized data base where all patients admitted to any hospital are documented. The date that the H&P is completed is noted, the data of discharge and the date the Hospital Care Summary is completed is also documented. This allows easy auditing of compliance with our standards of care. If the CBP (Central Business Office) has a question about a patient's admission or charges, they post the question to the IMRC and the Hospital Care Team researches the answer and posts the response.

When providers complete their rounds, they send a secure e-mail to the hospital-care team giving instructions for follow-up. This will include:

1. Testing or consultations required.
2. Reports which are needed
3. Screening and/or preventive healthcare issues needed such a flu, pneumonia, etc.
4. Discharge instructions
5. Treatments which need to be initiated

The Results

The hospital team will follow these instructions communicating throughout the day with the physician care team. SETMA hospital staff meets monthly with the hospital administration to review performance on:

1. Length of Stay
2. Case Mix Adjusted Lengths of Stay
3. 30-day readmission rates
4. Complications rates
5. Mortality rates
6. Core Measures
7. Average Cost of care
8. Pharmacy average Cost of care
9. Laboratory average cost of care
10. Imaging average cost of care
11. Percent discharges summaries completed in 24 hours
12. Percent Discharge orders given prior to noon
13. Case Mix Index .
14. Average Severity Level
15. Number of consultants used per case
16. Patient satisfaction with care

The results are that SETMA is 100% compliant with all core measures, with discharge summaries completed within 24 hours of discharge and SETMA has exemplary lengths of stays both unadjusted and adjusted.

Care While Inpatient

SETMA has the capability to complete daily progress notes in the EHR and the records completed there are vastly superior. However, we currently do not use this function because of the time required to do so. We are in the process of improving our connectivity with the hospital

via our Health Information Exchange (HIE). When the data points, which we collect on each patient each day at each visit, can be automatically placed in the EHR, it will be possible for us to resume this process.

At every hospital visit we want the following information to be in the record completed by the physician and documented in the daily progress note:

1. Blood pressure
2. Pulse
3. Pulse oxygenation
4. Percentage of oxygen the patient is on if any
5. Respiratory Rate
6. Temperature, current
7. Tmax – Maximum temperature over the past twenty-four hours
8. Bowel Movement in the past twenty-four hours
9. Diet
10. Appetite
11. Percentage of Food eaten
12. Is the patient ambulatory or not
13. Routine laboratory result from past 24 hours

The time required to place this in structure fields makes it impossible to routinely use the EHR until this is automated.

Transition from the inpatient to the outpatient or other setting

Two years ago, at a National Quality Forum (NQF) conference on Care Transitions, at which SETMA was an invited participant, we realized that the old name, "discharge summary," had lost any significance it may ever have had as a critical "transition of care" document. Therefore, we changed the name in September, 2010 to," Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan." Thus, this document became a kind of "baton" through which care can be effectively transitioned to the patient, to another person ,or to another entity.

The following poster is in every SETMA treatment room and a framed copy is found in every public area in all of our clinics. It illustrates this transition of care:

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.

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.
4. That typically the healthcare provider knows and understands the patient’s healthcare plan of care and the treatment plan, but that 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 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.
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.

The genius and the promise of the Patient-Centered Medical Home is 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, which must result in coordinated care. In 2011, as we expand the scope of SETMA's Department of Care Coordination, we know that coordination begins at the points of "transitions of care," and that the work of the healthcare team – patient and provider – is that together they evaluate, define and execute that care.