January 17, 2012
12:00 – 1:30 PM
Pappadeaux's Conference Room

Examining and Improving SETMA's Care Transition and Care Coordination

James L. Holly, MD

Supervising Partner for Care Transitions and Care Coordination

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. **Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan**
4. **Post Hospital Follow-up Coaching** -- a 12-30 minute call made by members of SETMA's Care Coordination Department and additional support
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 Readmissions

- 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 25,995 discharges from the hospital, 99.1% have had the Hospital Care Summary completed at the time the patient left the hospital.

Care Transitions & Hospital Readmissions

- 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 Readmissions

- 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 Readmissions

- 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 Readmissions

- 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.**

Performance

- For October, November and December 2011, we had 1112 discharges.
- 976 (87.8%) of those visits had a follow-up call scheduled and 756 (77.5%) of those had the call completed.

SETMA's Performance

- At the eHealth Initiative meeting, during a panel discussion, I reviewed SETMA's Care Transitions and Care Coordination program. When I finished, spontaneous applause broke out. Everything others were thinking of doing, trying to do or wanting to do, SETMA is doing.

Preventable Readmissions

There are only two things which make a difference in preventable readmissions:

1. Did patients receive their care coaching, hospital discharge call the day following discharge?

2. Was the patient seen within six days of discharge?

New Goals

There are four goals which we are going to establish today:

1. Medication reconciliation is going to be done and be done right
2. All patients are going to receive a care-coaching follow-up call
3. All frail, vulnerable patients who are at high risk of being readmitted will be seen within three days
4. All other patients will be seen within six days of discharge from the hospital

Missed Appointments

If patients do not keep their follow-up appointment:

1. The Care Coordination Department will be notified
2. A call that day will be made to the patient
3. A home visit will be made to the most vulnerable by SETMA's new MSW

Pat Crawford

Director, Department of Care Coordination

Issues - Medications

- Medications not being correct in the EHR.
- This is a problem that both the hospital team and the care coordination team deal with daily. Fortunately for us, the hospital team is always available by email and respond quickly to our questions.

Issues - Medications

- Medication profile in chart showing updated as if the patient was given a script at the time of discharge but the patient does not have the written scripts and/or the pharmacy does not show it as called in by the physician.
- Applies mostly to the narcotics which become a very big problem. If the quantity and/or the number of refills are filled out on the med profile it means to us that it has been refilled.

Issues - Medications

- Medications changed by the specialist after the hospital team has completed the discharge. We then have to trust that the patient has the correct medication and dosage and understands how to administer the medication correctly.

Issues - Medications

- Any narcotics at discharge, even if the patient was on the narcotic prior to the hospitalization, the discharging physician does not always want to give a prescription or refill at discharge.

Issues - Appointments

- Appointments not in the time frame required.
  - Over 65 – 3 days.
  - Under 65 – 5 days.

Issues – Follow-Up

- Patients not feeling well enough to come in to the office as needed after discharge.
- Patients that do not have caregivers at home to assist in transition and follow-up.

Issues – Home Health

- Home Health services needing to be in place in certain situations before the patient arrives at home. Can be a terrible problem if this occurs on a Friday and we are not aware of this until Monday…the patient has been 2 days without services needed. (ex: Wound care, Lovenox injections, wound vac, etc.)
- Does not happen very often but has occurred recently.

Issues – Lack of Information

- Patients not being given enough information about their illness and care needed.

Problems – Mid County

- Mid-County patients that go to The Medical Center have very little information for follow-up. Some do not even have correct phone numbers. This would be a problem from the business office at that facility. Most of these patients to date have PCP's outside of SETMA.

Common Patient Complaints

1. Physicians not spending time with the patient in the room.
2. Physicians not talking with the patient and/or the family to explain the illness and plan of treatment.
3. Test results not being discussed.
4. Being discharged from the hospital too quickly.
5. Patients not being able to see their SETMA PCP while in the hospital.

Common Patient Complaints

6. Patients not wanting to see anyone but their PCP after discharge.
7. Patient's being told by the physician they have an appt with that he/she cannot help them and they must make a follow-up appt with their PCP. *This occurs within the SETMA system – not outside PCP's.*
8. On discharge day, the discharge summary given to the patient by the nurse on the unit can conflict with the SETMA discharge summaries in the chart.

Common Patient Complaints

9. Patient education…medications and patient responsibility for care. A lot of the elderly patients do not understand that there is no longer a system that allows home health to come out and help them set up meds and check on them.
10. Hospice care sometimes not being fully discussed or more probably not being understood by the family.

Brandon Sheehan, RN

Director, Department of Care Transitions and Hospital Care Team

Common Causes for Readmission

1. Patient was not physically improved enough to be discharged to the setting they were discharged to. The best plan IS NOT ALWAYS transitioning the patient to another facility or home. Sometimes there are appropriate reasons for keeping a patient in the hospital a little longer. Sometimes this is all it takes to prevent a readmission. I am not saying we keep patients in the hospital until they "want" to go, just that we keep them in until its safe and they are well enough to go home.

Common Causes for Readmission

2. Patient and/or family felt that their problem was not appropriately addressed or managed. On the flip side there are some that are just always going to come back.
3. Patient and/or family thought they had more support to manage at home than they actually did.

Common Causes for Readmission

4. Patient and/or family were not asked what support they have in the home.
5. Families and/or patients don't always accept the situation they are in at the time of discharge. Families very seldom agree that custodial care is what stage the patient is at and continue to try to fight the down hill slide despite our explanations and recommendations.

Common Causes for Readmission

6. Appropriate follow up does not happen as scheduled or was not scheduled.
7. Unseen complications: with wounds, pts that are post procedures, post MI's, complications from medication changes.
8. Untreated or unaddressed conditions/complications - constipation, cough, UTI, pneumonia, and weakness.

Common Causes for Readmission

9. Discharge Medications. What we need is the physician to review the patients' admission medications ***THEN*** review what changes have been made during the hospital stay ***THEN,*** based on diagnoses, lab data and current medications in the hospital, fill out the hospitals DC medications form. Each hospital now can print a list of all these for review and you can circle or write instructions on these sheets for us to follow.
   - Most times we get "continue home medications" or "continue previous medication" but then all changes made in the hospital are erased.
   - The other problem is that when home meds were not restarted and then the order is to "continue home medications" or "continue previous medication" some of those meds do need to be restarted, some do not.

Common Causes for Readmission

10. MEDICATION LISTS ARE CONFUSING TO US, JUST IMAGINE HOW THE PATIENTS AND FAMLIES FEEL.
    - On admission, med profile is seldom correct. Incorrect meds, dosages, and frequency. Patients say things like "well I was having more swelling and in the office and the doctor told me to start taking 2 of those pills" and the meds are not reflecting the changes.
    - Patients see MULTIPLE specialists who change medications and those changes don't get relayed to us.

Common Causes for Readmission

10. MEDICATION LISTS ARE CONFUSING TO US, JUST IMAGINE HOW THE PATIENTS AND FAMLIES FEEL.
    - Sometimes the home medication list that the hospital has is not what the patient is actually taking.
    - Hospital team may do a Discharge as ordered by the rounding MD then a consult may make medication change.
    - Sometimes the patients are not taking medications as they were instructed or at all because of side effects or cost or they don't think they need to.