

Healthcare Informatics Executive Summit 2012

**Readmissions and the Medical Home:
Re-Visioning Care Management**

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9:30 – 10:45 AM

E07

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ACO Integrator: Exercise in Accountability

The following discussion addresses how SETMA which participates in Medicare Advantage capitation, Patient-Centered Medical Home and in a federally qualified ACO, addresses one of the biggest challenges to success which is decreasing preventable readmissions to the hospital.

Preventable Hospital Readmissions Public Policy

- Care planning that begins with an assessment at admission — nurse care managers representing the insurer, the hospital, and the primary providers must collaborate.
- Clear discharge instructions with particular attention to medication management — incorporating the input of the inpatient and outpatient pharmacist has proven effective.
- Discharge to a proper setting of care — Hospital case management screenings should determine rehab/skilled nursing requirements before discharge to outpatient care.

Preventable Hospital Readmissions Public Policy

- Timely physician follow-up visits — with primary care provider and appropriate specialists; preferably the appointment should be scheduled prior to discharge.
- Appropriate use of palliative care and end-of-life planning should be built into the hospital discharge process. Palliative specialists and hospice expertise need to be integrated components of post-hospital planning.

SETMA's Hospital Discharges

Total Discharges			Readmission Rate (Days)	
			30	60
• 2009	—	2995	--	--
• 2010	—	3001	16.5%	21.9%
• 2011	—	4194	17.4%	24.6%
• 2012 *	—	946	--	--
• Total	—	11055	--	--

*Jan, Feb 2012

CMS Fee For Service Medicare Study – Medical Homes vs. Benchmarks

	30 Day Readmission (%)	Benchmark (%)		Two Week (%) Follow-Up	Benchmark (%)		Potentially Avoidable Inpatient Stays (\$)	Benchmark (\$)
SETMA 1	25.7	47.7		57.8	47.7		1766.00	3290.00
SETMA 2	17.5	30.9		56.5	40.4		962.00	2259.00
SETMA West	20.0	14.4		56.9	62.0		731.00	300.00

Care Transition Audit

- 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.
- The following is the care transition audit results by provider name for 2011.

Care Transition Audit



Care Transition Audit (Section A)

Discharge Date(s): 01/01/2012 through 03/31/2012

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
Anwar	97.4%	99.1%	94.9%	98.3%	98.3%	97.4%	98.3%	96.6%	97.4%
Aziz	98.9%	100.0%	96.6%	100.0%	99.4%	98.9%	99.4%	98.9%	98.9%
Curry	100.0%	96.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Deiparine	97.9%	98.7%	95.7%	98.3%	99.1%	98.3%	98.7%	97.0%	97.9%
Gulfcoast	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	100.0%	100.0%	98.6%	98.6%	100.0%	100.0%	98.6%	100.0%	98.6%
Holly	97.6%	99.5%	96.7%	98.6%	99.0%	97.6%	97.1%	97.1%	98.1%
Leifeste	99.5%	100.0%	99.5%	99.5%	99.5%	100.0%	98.9%	99.5%	99.5%
Murphy	100.0%	100.0%	98.6%	98.6%	100.0%	100.0%	100.0%	100.0%	100.0%
Palang	100.0%	100.0%	100.0%	100.0%	98.6%	100.0%	98.6%	100.0%	98.6%
Qureshi	98.3%	100.0%	93.9%	98.3%	98.3%	97.4%	97.4%	97.4%	97.4%
Shepherd	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	97.7%	100.0%	93.7%	99.5%	99.5%	97.7%	98.2%	97.7%	97.7%
Vardiman	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
SETMA Totals :	98.5%	99.6%	96.5%	99.0%	99.2%	98.5%	98.5%	98.1%	98.3%

Care Transition Audit



Care Transition Audit (Section B)

Discharge Date(s): 01/01/2012 through 03/31/2012

Provider	Advanced Directives	Reason for Discharge	Physical Status	Psychosocial Status	Community Resources Coordinated Referrals	Medication List	Discharge Orders	Follow-Up Instructions	Discharge Materials
Anwar	94.9%	97.4%	98.3%	97.4%	95.7%	94.0%	94.0%	94.0%	94.0%
Aziz	96.6%	98.9%	99.4%	98.9%	94.9%	96.1%	96.1%	96.1%	94.9%
Curry	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Deiparine	95.7%	97.9%	99.1%	98.7%	94.8%	94.8%	94.8%	94.8%	94.4%
Gulfcoast	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	98.6%	98.6%	100.0%	100.0%	95.8%	98.6%	97.2%	95.8%	93.0%
Holly	96.7%	98.1%	99.0%	98.6%	96.2%	94.8%	94.8%	94.8%	94.8%
Leifeste	98.9%	100.0%	99.5%	99.5%	97.3%	98.9%	98.9%	98.9%	98.4%
Murphy	98.6%	100.0%	100.0%	100.0%	97.1%	98.6%	98.6%	97.1%	97.1%
Palang	100.0%	100.0%	98.6%	100.0%	97.3%	100.0%	100.0%	98.6%	98.6%
Qureshi	93.9%	98.3%	98.3%	98.3%	94.8%	92.2%	92.2%	92.2%	92.2%
Shepherd	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	93.7%	97.3%	99.5%	98.2%	97.3%	93.2%	93.2%	92.8%	93.2%
Vardiman	100.0%	100.0%	100.0%	100.0%	92.9%	100.0%	100.0%	100.0%	100.0%
SETMA Totals :	96.4%	98.5%	99.2%	98.8%	96.1%	95.7%	95.6%	95.4%	95.0%

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

Hospital Care Summary

Admission Date 04/09/2011
Discharge Date 04/11/2011

Facility Memorial Hermann Baptist
Type Discharge Summary
Scheduled Admission ☐ Yes ☒ No

Admitting Diagnosis	Status	Discharge Diagnosis	Status
Abd Pain Generalized	Acute	Abd Pain Generalized	Chronic
COPD	Chronic	COPD	Chronic
Drug Depend Opioid Oth Epis	Chronic	Drug Depend Opioid Oth Epis	Noncompliant
Tobaccoism -- Use Disorder	Chronic	Tobaccoism -- Use Disorder	Chronic
		Hypotension Chronic	holding Metoprolol
		Anemia Unspecified	Chronic

Discharge Condition stable
Prognosis poor
☐ Additional materials from hospital scanned into ICS

Discharge Time ☒ 1 - 31 minutes ☐ > 31 minutes
Days in ICU
Days on IV Antibiotics
Days on Ventilator

[Additional Admitting Dx](#)
[Additional Discharge Dx](#)

Assessments into Problem List

Admitting Chronic Conditions	Discharge Chronic Conditions
Esophageal Reflux	Esophageal Reflux
COPD / Atrial Fibrillation	COPD / Atrial Fibrillation
Anxiety Disorder General	Anxiety Disorder General
Menopausal Post Status	Menopausal Post Status
Spine Lumbar Pain Lumbago	Spine Lumbar Pain Lumbago
Fibromyalgia Fibrositis	Fibromyalgia Fibrositis
Allergic Rhinitis NOS	Allergic Rhinitis NOS
Asthma Reactive Airway Dis	Asthma Reactive Airway Dis
Hernia Ventral W/O Obstructi	Hernia Ventral W/O Obstructi
Osteoporosis Postmenopaus	Osteoporosis Postmenopaus
Urinary Incontinen Other	Urinary Incontinen Other
Tobaccoism	Tobaccoism
Hyperten Benign Essential	Hyperten Benign Essential
Retina Vasuclar Changes	Retina Vasuclar Changes
Spine Degen Disc Lumbar	Spine Degen Disc Lumbar

Fall Risk Assessment
Functional Assessment
Pain Assessment
Last Hospital Discharge Medication Reconciliation
Hospital Follow-Up Call

04/11/2011
04/11/2011
04/11/2011
04/11/2011

Surgeries This Stay

//
//
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Care Transition Audit

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

Hospital Care Summary completed at the time the patient is discharged from the hospital:

<u>Year</u>	<u>Completion (%)</u>
2010	98.8
2011	97.7
2012*	92.1
Cumulative	97.7

* January 1, 2010 to date

Hospital Readmission Reporting



Hospital Discharge Analysis

Section I - Admissions and Follow-ups

Prompt Selections		
	<u>Selection Group 1</u>	<u>Selection Group 2</u>
Beginning Discharge Date:	Jan 1, 2011	Jan 1, 2011
Ending Discharge Date:	Dec 31, 2011	Dec 31, 2011
Include Readmits:	Within 30 days	Not Within 30 days
Ethnicity:	All	All
Financial Class:	All	All
Zip Code:	All	All
Age:	All	All
Gender:	Both	Both
Living Arrangement:	None Selected	None Selected
Encounters for this Selection:	679	3226

	<u>Selection Group 1</u>	<u>Selection Group 2</u>
Readmission		
Average Days:	11.81	
Mode:	1.00	
Previous Hospitalization		
Average Days:	9.39	10.24
Mode:	2.00	2.00
Follow-up (Clinic Visit)		
Average Days:	6.65	18.14
Follow-up Visit (%):	37.85%	68.04%
Follow-up (Call)		
Call Completed (%):	74.67%	77.53%
Unable to Complete (%):	6.48%	6.91%

Hospital Readmission Reporting



Hospital Discharge Analysis

Section II - Patient Measures

Prompt Selections		
	<u>Selection Group 1</u>	<u>Selection Group 2</u>
Beginning Discharge Date:	Jan 1, 2011	Jan 1, 2011
Ending Discharge Date:	Dec 31, 2011	Dec 31, 2011
Include Readmits:	Within 30 days	Not Within 30 days
Ethnicity:	All	All
Financial Class:	All	All
Zip Code:	All	All
Age:	All	All
Gender:	Both	Both
Living Arrangement:	None Selected	None Selected
Encounters for this Selection:	679	3226

	<u>Selection Group 1</u>	<u>Selection Group 2</u>
Ancillary Services		
Hospice:	1.62%	1.36%
Home Health:	4.27%	2.82%
Physical Therapy:	0.15%	0.25%
Case Management:	0.00%	0.00%
Assisted Living:	0.44%	0.37%
Nursing Home:	21.35%	16.24%
Living Alone		
Patient Lives Alone:	1.62%	2.39%
Barriers to Care		
Financial Barriers:	5.60%	4.90%
Social Barriers:	5.30%	6.54%
Assistive Device:	12.96%	9.02%
Habits		
Tobacco Use:	21.35%	23.47%
Alcohol Use:	10.16%	12.24%
Illicit Drug Use:	2.50%	1.64%
Disease - Not in Compliance		
Diabetic:	40.95%	39.20%
Hyperlipidemia:	23.60%	28.43%
Hypertension:	23.77%	22.72%
CHF:	89.45%	88.51%
Care Transition Audit		
Transition Audit Completed:	94.85%	94.17%

Hospital Readmission Reporting



Hospital Discharge Analysis

Section III - Patient BMI and Changes Made

Prompt Selections		
	<u>Selection Group 1</u>	<u>Selection Group 2</u>
Beginning Discharge Date:	Jan 1, 2011	Jan 1, 2011
Ending Discharge Date:	Dec 31, 2011	Dec 31, 2011
Include Readmits:	Within 30 days	Not Within 30 days
Ethnicity:	All	All
Financial Class:	All	All
Zip Code:	All	All
Age:	All	All
Gender:	Both	Both
Living Arrangement:	None Selected	None Selected
Encounters for this Selection:	679	3226

Selection Group 1

Selection Group 2

Body Mass Index

Less than 18.5:	6.04%	6.82%
Between 18.5 and 25:	24.59%	23.93%
Between 25 and 30:	28.13%	25.26%
Between 30 and 35:	15.46%	18.07%
Between 35 and 40:	9.43%	8.18%
Greater than 40:	7.81%	8.65%

Hospital Readmission Reporting



Hospital Discharge Analysis

Section IV - Readmission Diagnoses

Prompt Selections		
	<u>Selection Group 1</u>	<u>Selection Group 2</u>
Beginning Discharge Date:	Jan 1, 2011	Jan 1, 2011
Ending Discharge Date:	Dec 31, 2011	Dec 31, 2011
Include Readmits:	Within 30 days	Not Within 30 days
Ethnicity:	All	All
Financial Class:	All	All
Zip Code:	All	All
Age:	All	All
Gender:	Both	Both
Living Arrangement:	None Selected	None Selected
Encounters for this Selection:	679	3226

Selection Group 1

Top 5 Principle Diagnoses of Readmission

Rank	Readmission Diagnoses	Description
1	78650	Symp resp unsp chest pain
2	78605	Shortness Of Breath
3	486	Pneumonia organism NOS
4	78097	Altered Mental Status
5	5789	Hem gi tract

Top 5 Supporting Diagnoses of Readmission

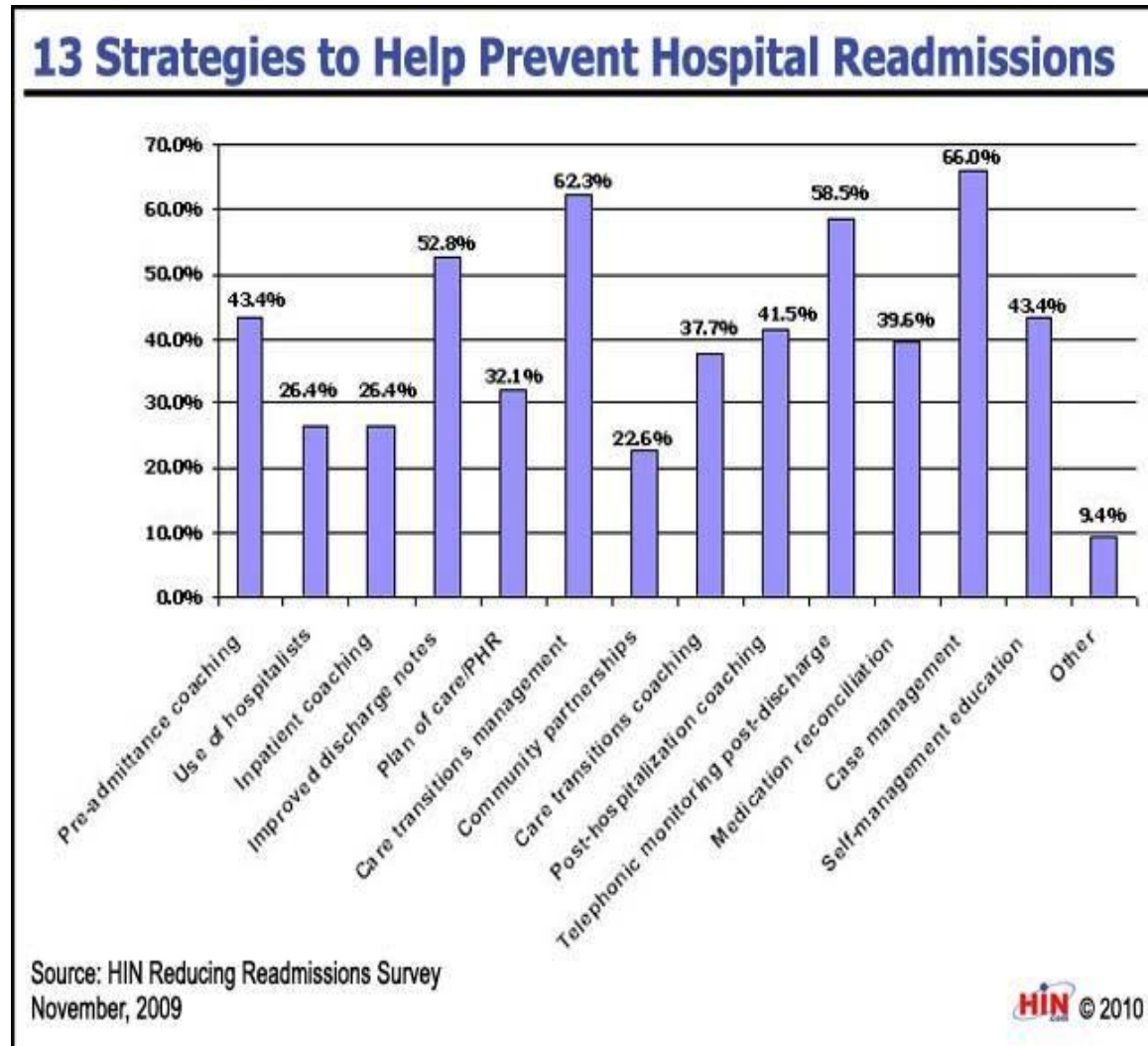
Rank	Readmission Diagnoses	Description
1	4011	Essential hypertension benign
2	4019	Essential hypertension unsp
3	496	Chronic airway obstruction NEC
4	2859	Anemia unsp
5	25040	Diab mellitus ren manif typ II

Selection Group 2

Rank	Readmission Diagnoses	Description
1	78650	Symp resp unsp chest pain
2	78605	Shortness Of Breath
3	7802	Gen symp syncope/collapse
4	2859	Anemia unsp
5	486	Pneumonia organism NOS

Rank	Readmission Diagnoses	Description
1	4019	Essential hypertension unsp
2	4011	Essential hypertension benign
3	25040	Diab mellitus ren manif typ II
4	2859	Anemia unsp
5	41400	Coron athero unsp typ ves nati

Hospital Readmission Strategies



All Readmissions Are Not Preventable

“Critical to the analysis of readmissions is appropriateness. Some readmissions may be unavoidable. Other readmissions may be avoidable, but nevertheless occur, due to a *lack* of follow-up care coordination or some other problem. Obtaining a readmissions rate of zero is not feasible and may even indicate poor quality care, as many readmissions are medically appropriate due to an unavoidable change in condition or a new condition. For example, physicians may provide patient centered care by discussing early discharge with patients, with the mutual understanding that readmission may be necessary.”

Risk of Readmissions

Recent studies continue to suggest the risk of readmission can be quantified based on a patient's risk factors and therefore are an important tool in establishing evidence-based best practices.

Risk of Readmissions

- The *Journal of Hospital Medicine* recently published a pair of studies in which researchers analyzed data from California and Austria to determine the risk factors of hospital readmission.
 - Medicare
 - Medicaid
 - Black Race
 - Inpatient use of narcotics
 - Inpatient use of corticosteroids
 - Cancer with and without metastasis
 - Renal Failure
 - Congestive Heart Failure
 - Weight loss

Risk of Readmissions

Hospital Care Summary

Admission Date / /
Discharge Date / /

Facility /
Type Discharge Summary
Scheduled Admission ☐ Yes ☐ No

Admitting Diagnosis	Status	Discharge Diagnosis	Status

[Re-order](#)

Discharging To
Discharge Condition
Prognosis

☐ High risk for readmission?

[Additional Admitting Dx](#)
[Additional Discharge Dx](#)

Admitting Chronic Conditions

COPD (chronic obstructive pu	
COPD (chronic obstructive pu	
CHF (congestive heart failure)	
Hyperlipidemia	
Allergic rhinitis with asthma w	
Asthma	
Pre-diabetes	
Diabetes mellitus associated v	

Discharge Chronic Conditions

COPD (chronic obstructive pulmonary	
COPD (chronic obstructive pulmonary	
CHF (congestive heart failure)	
Hyperlipidemia	
Allergic rhinitis with asthma without st	
Asthma	
Pre-diabetes	
Diabetes mellitus associated with re	

[Re-order](#)

Discharge Time ☐ 1 - 31 minutes ☐ > 31 minutes
Days in ICU
Days on IV Antibiotics
Days on Ventilator

Fall Risk Assessment
Functional Assessment
Pain Assessment
Last Hospital Discharge Medication Reconciliation
Hospital Follow-Up Call

03/05/2012
04/01/2011
04/01/2011
12/02/2009

Surgeries This Stay

	/ /
	/ /
	/ /

Care Transition Audit

Follow-Up Exceptions

☐ Patient To Follow-Up With Non-SETMA Provider
☐ Patient Ok To Follow-Up > 6 Days

Home
Histories
Health
System Review
Physical Exam
Procedures
Radiology
EKG
Laboratory
Hydration
Nutrition
Hospital Course
Nursing Home
Follow-up Instr
Follow-up Loc
Document
Follow-Up Doc

Managing High Risk Patients

When a person is identified as a high risk for readmissions, SETMA's Department of Care Coordination is alerted. The following ten steps are then instituted:

- 1. *Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan*** is given to patient, care giver or family member.
2. The post hospital, care coaching call, which is done the day after discharge, goes to the top of the queue for the call – made the day after discharge by SETMA's Care Coordination Department. It is a 12-30 minute call.

Managing High Risk Patients

3. Medication reconciliation is done at the time of discharge, is repeated in the care coordination call the day after discharge and is repeated at the follow-up visit in the clinic.
4. MSW makes a home visit for need evaluation, including barriers and social needs for those who are socially isolated.
5. A clinic follow-up visit within three days for those at high risk for readmission.

Managing High Risk Patients

6. A second care coordination call in four days.
7. Plan of care and treatment plan discussed with patient, family and/or care giver at EVERY visit and a written copy with the patient's reconciled medication list, follow-up instructions, state of health, and how to access further care needs.
8. MSW documents barriers to care and care coordination department designs a solution for each.

Managing High Risk Patients

9. The patient's end of life choices and code status are discussed and when appropriate hospice is recommended.
10. Referral to disease management is done when appropriate, along with telehealth monitoring measures.

Managing High Risk Patients

- Currently, SETMA's determination of whether patients are high risk for readmissions is intuitively determined, i.e., at discharged based on experience and judgment, a patient is designated as potentially high risk for readmission. SETMA is designing a "predictive model" for identifying patients at high risk for readmissions and instituting the above plan for interdicting a readmission. This is an attempt to quantify the most effective opportunities for decreasing preventable readmissions.

Managing High Risk Patients

- There is a significant body of science associated with “**predictive modeling.**” It is clear that traditional models of care delivery will not “work” in a sustainable program for decreasing readmissions. Traditional disease management will not result in changing the patterns of care. In a January/February, 2012 *Professional Care Management* Journal article, the following abstract addressed changes needed to affect a decrease in preventable readmissions:

Managing High Risk Patients

- **“Purpose/Objectives:** The move to the Accountable Care Organization model of care calls for broad-sweeping structural, operational, and cultural changes in our health care systems. The use of predictive modeling as part of the discharge process is used as a way to highlight just one of the common processes that will need to be transformed to maximize reimbursement under the Accountable Care Organization model. The purpose of this article is to summarize what has been learned about predictive modeling from the population health management industry perspective, to discuss how that knowledge might be applied to discharge planning in the Accountable Care Organization model of patient care, and then to outline how the Accountable Care Organization environment presents various challenges, opportunities, and implications for the case management role.”

Managing High Risk Patients

- **“Findings/Conclusions:** The development of predictive models to identify patients at risk for readmission and can positively impact the discharge planning process by lowering readmission rates. Examples of the structural, operational, cultural, and case management role changes necessary to maximize the benefits of an Accountable Care Organization are critical.”
- **“Implications for Case Management Practice:** There is a growing need for advanced practice nurses to fill the leadership, resource management, analytical, informatics-based, and organizational development roles that are sorely needed to advance the Accountable Care Organization model of care. Case managers are well-positioned to lend their expertise to the development efforts, but they will need to be educationally prepared for the many advanced practice roles that will emerge as our nation evolves this new system of health care delivery.”

National Priorities Partnership

Focus in care coordination by NPP are the links between:

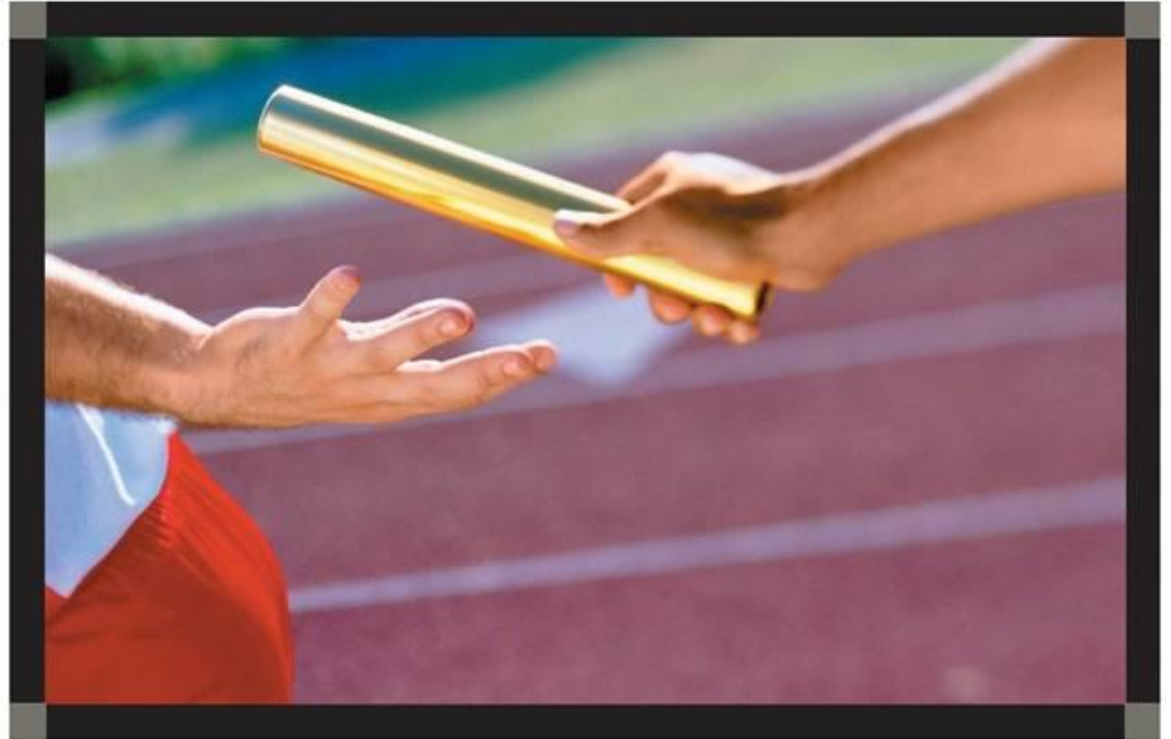
- **Care Transitions** - ...continually strive to improve care by ... considering feedback from all patients and their families... regarding coordination of their care during transitions between healthcare systems and services, and...communities.
- **Preventable Readmissions** - ...work collaboratively with patients to reduce preventable 30-day readmission rates.

Hospital Care Summary

- 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/or to the patient's family and to the hospital.

An Integrator's Tool: The Baton

The following picture is a portrayal of the “plan of care and treatment plan” which is like the “baton” in a relay race.



■
Firmly in the provider's 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.
■

An Integrator's Tool: The Baton

“The Baton” 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 provider's 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.

-

An Integrator's Tool: The Baton

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.

An Integrator's Tool: The Baton

4. That typically the healthcare provider knows and understands the patient's healthcare plan of care and the treatment plan, but 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 must 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.**

An Integrator's Tool: The Baton

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.

An Integrator's Tool: The Baton

After the care transition audit is completed and the document is generated, the provider completes the Hospital-Follow-up-Call document:

Hospital Discharge Follow-Up Call **Return**

Number to Call ☐ Home Phone (409)892-0021
☐ Day Phone () -
☐ Other () - [Send Delayed-Delivery Email to Follow-Up Nurse](#)

Admit Date 04/09/2011
 Discharge Date 04/11/2011
 Setting ☐ ER ☐ In Patient
 Hospice Texas Home Health
 Home Health

Discharge Diagnoses

Abd Pain Generalized
COPD
Drug Depend Opioid Oth Epis
Tobaccoism -- Use Disorder
Hypotension Chronic
Anemia Unspecified

Diet Regular
Exercise

Call Attempts

<input checked="" type="checkbox"/>	1	04/12/2011	1:52 PM
<input type="checkbox"/>	2	//	
<input type="checkbox"/>	3	//	
<input type="checkbox"/>	Unable to Call, Letter Sent		
		//	

Questions to Ask

General

☒ How are you feeling?
☒ Are you having new symptoms since hospital stay?
☐ Have you obtained all DME that you were prescribed?
 Other
☐ You have been scheduled to see a SETMA provider (Dr. He

Medications

☐ Were you able to get all of your medications filled?
☒ Are you taking all of your prescribed medications?
☒ Are you having any problems/side effects from your medications?

Appointments

Have you kept or are you aware of your appointment(s) with...?

Dumitru	Adrian	on	//
		on	//
		on	//

Patient Responses

How does the patient feel?
 Is the patient having new symptoms?

Is the patient taking all of their medications?
 Is the patient having any problems/side effects?

Has the patient kept and/or aware of all scheduled appointments or referrals?
 Additional Comments

Actions Taken

☐ Advised Patient To Come In - Made Same-Day Appointment
☐ Advised Patient To Call If Improvement Discontinues
☐ Advised Patient To Continue Medications
 Other

New Referrals from Visit (This Visit Only)

Status	Priority	Referral	Referring Provider
Completed	Immediate	Abdominal US	

New/Changed Medications from Visit (This Visit Only)

Generic Name	Brand Name	Dose
ALPRAZOLAM	XANAX	1 mg
ALPRAZOLAM	XANAX	1 mg
BISACODYL	DULCOLAX	10 mg
BUSPIRONE HCL	BUSPAR	10 mg

Click to Document Completion **Click to Send Response** **Follow-Up Call Completed By** At //

Spoke with the patient? ☐ Yes ☐ No
 If no, list person spoken with.

An Integrator's Tool: The Baton

- During that preparation of the “baton,” 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.
- The call is the beginning of the “**coaching**” of the patient to help make them successful in the transition from the inpatient setting.

Preventing Hospital Readmission

1. The problem of readmissions will not be solved by more care: more medicines, more tests, more visits, etc.
2. The problem will be solved by redirecting the patient's attention for a safety net away from the emergency department.
3. The problem will be solved by our having more proactive contact with the patient.

Preventing Hospital Readmission

4. The problem will be solved by more contact with the patient and/or care giver in the home: home health, social worker, provider house calls.
5. The problem will be solved by the patient and/or care giver having more contact electronically (telephone, e-mail, web portal, cell phone) with the patient giving immediate if not instantaneous access.