SETMA's Transitions of Care Initiative to Reduce Preventable Readmissions

Institute for Healthcare Improvement STAAR -- Shining the Spotlight Call

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Dr. James L. Holly, CEO
Southeast Texas Medical Associates, LLP
Adjunct Professor, Family/Community Medicine
University of Texas Health Science Center
San Antonio, School of Medicine

Introduction

1. Medium sized multi-specialty practice in SE Texas
2. Adopted EMR, March 30, 1998
3. Saw first patient on EMR, January 26, 1999
4. Morphed to Electronic Patient Management, May, 1999
5. First Disease Management Tool deployed, January, 2000
6. Same EMR data base utilized at all points of service, October, 2000
7. HIMSS Davies Award Winner, January, 2005
8. BI Analytics & Public Reporting, October. 2009
9. NCQA Tier III Medical Home, July, 2010
10. NCQA Diabetes Recognition, August, 2010
11. AAAHC Medical Home & Ambulatory Care, August, 2010
12. Joslin Diabetes Affiliate, September, 2010
13. Named one of 30 Exemplary Practices by Robert Wood Johnson Foundation for LEAP Study, September, 2012
14. HIMSS 2012 Physician IT Leadership Award, 2012, February, 2013

OBJECTIVEES

1. Examine link between Care Transitions and Readmissions
2. Review SETMA's Model of Care
3. Review SETMA's Care Transition
4. Address Risk of Readmission – High Risk
5. BI Analytics to find leverage points for improvement
6. 30 Day Readmission Rates
7. Care Coordination and SETMA Foundation
8. Transition of Care Management Codes
9. Appendix – IHI Support: "The Baton"

SETMA's Model of Care

http://www.jameslhollymd.com/the-setma-way/setma-model-of-care-pc-mh-healthcare-innovation-the-future-of-healthcare

This link is to a description of the SETMA Model of Care:

1. Tracking of 300 quality metrics at POC on all patients.
2. Auditing performance by populations and/or by panel of patients
3. Statistically analyzing process and outcomes metrics looking for leverage points for performance improvement
4. Public Reporting by provider name of performance.
5. Designing Quality Improvement on the basis of these four steps.

National Priorities Partnership

The focus in care coordination addressed 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.

SETMA's Care Transitions

SETMA's Care Transition involves:

1. Evaluation at admission – transition issues: "lives alone," barriers, DME, residential care, medication reconciliation, or other needs
2. Fulfillment of PCPI Care Transitions Quality Metric Set
3. Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan at discharge
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 within in 2-4 days, which is the last critical step in Care Transitions

1. Evaluation At Admission

- Barriers to Care including support requirements
- **Does the patient live alone**? (ICD-9 V603; ICD-10 Z602; SNOMED "Lives Alone – No Help Available")
- Activities of Daily Living – is the patient safe to live independently
- **Hospital Plan of Care a document** given to patient/family at admission -- includes potential for re-hospitalization, estimated length of stay, why hospitalized, expected length of hospitalization, procedures and tests planned, contact information for how to call hospital-team members.
- Establishes communication with all who are involved in patient's care: attending, nursing staff, hospital service team, family.
- Links ambulatory patient activation to inpatient activation.

2. Fulfillment of Quality Metric Sets

- SETMA has completed “Discharge Summaries “ in ambulatory EMR since the year 2000.
- June, 2009, PCPI published Transitions of Care Quality Metric Set
- SETMA adopted PCPI Measurement Set immediately

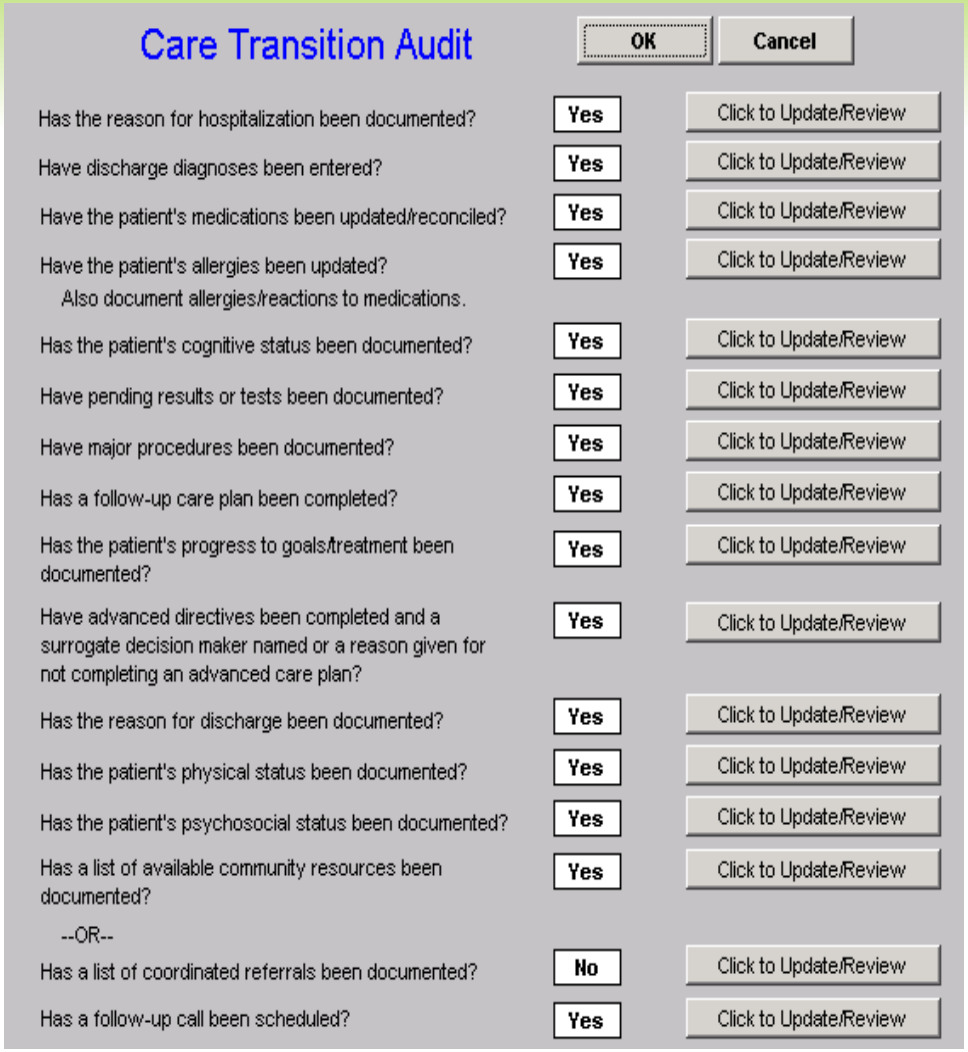
SETMA’s Quality Metrics Philosophy

The Limitations of Quality Metrics

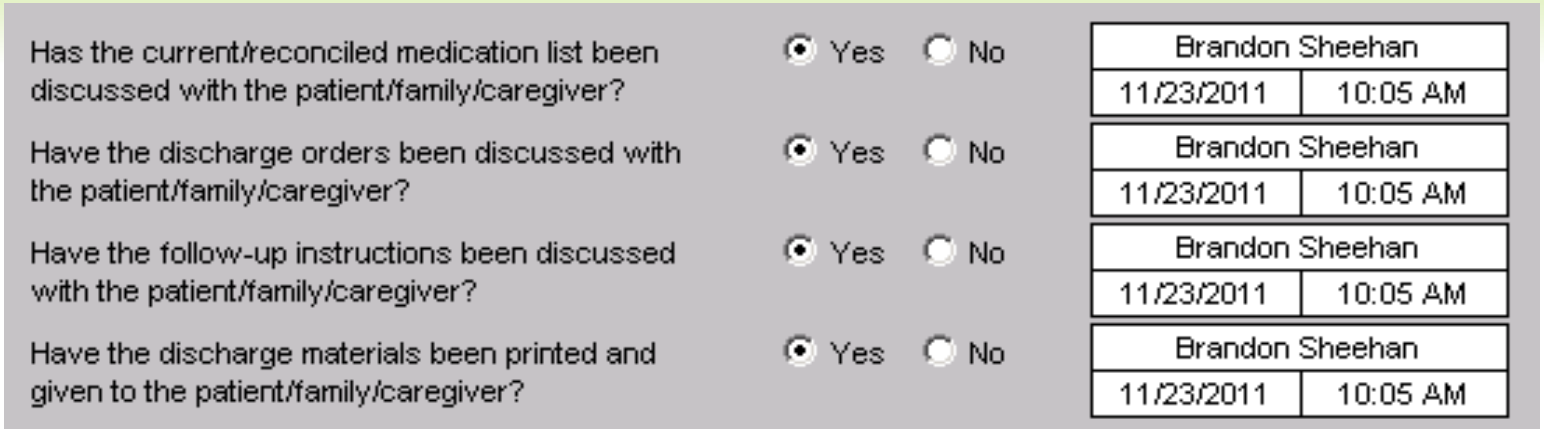
- SETMA began Public reporting by provider name at www.jameslhollymd.com of performance on quality metric sets for 2009-First Quarter 2013.
- In 2011 completed research project with AMA to determine if SETMA’s fulfillment of measures is valid. The answer? “Yes.”

Care Transition Audit

The PCPI Measurement Set involves 14 actions which are audited. SETMA's deployment is such that if at the end of the documentation of the Hospital Care Summary, any of the metrics not met (appear in red), the "Click to Update/review" button can be depressed. This will take the provider to the point in the document where that element should be documented.



Care Transition Audit



Has the current/reconciled medication list been discussed with the patient/family/caregiver?	◉ Yes	○ No	Brandon Sheehan	11/23/2011 10:05 AM
Have the discharge orders been discussed with the patient/family/caregiver?	◉ Yes	○ No	Brandon Sheehan	11/23/2011 10:05 AM
Have the follow-up instructions been discussed with the patient/family/caregiver?	◉ Yes	○ No	Brandon Sheehan	11/23/2011 10:05 AM
Have the discharge materials been printed and given to the patient/family/caregiver?	◉ Yes	○ No	Brandon Sheehan	11/23/2011 10:05 AM

The PCPI Measurement Set also involves 4 actions which must be completed. These actions are documented by the provider who completes the Hospital Care Summary by entering his/her name and the time and date of completion.

Care Transition Audit Publicly reported at www.jameslhollymd.com

Care Transition Audit (Section A)

Discharge Date(s): 01/01/2013 through 04/30/2013

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	98.7%	100.0%	97.4%	98.7%	98.1%	98.1%	98.7%	98.1%	98.1%
Aziz	98.0%	98.7%	96.6%	98.7%	99.3%	98.0%	97.3%	98.7%	98.0%
Deiparine, C	97.9%	100.0%	96.7%	98.8%	98.8%	97.9%	99.1%	97.6%	98.2%
Duncan	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	98.0%	100.0%	99.0%	100.0%	100.0%	99.0%	99.0%	99.0%	99.0%
Holly	98.8%	100.0%	96.0%	98.4%	98.4%	98.0%	98.8%	97.2%	98.8%
Le	96.7%	100.0%	94.6%	98.9%	100.0%	95.7%	96.7%	96.7%	96.7%
Leifeste	98.7%	100.0%	98.2%	98.7%	99.6%	98.2%	99.1%	99.1%	98.7%
Murphy	98.6%	98.6%	98.6%	100.0%	100.0%	98.6%	98.6%	98.6%	98.6%
Palang	100.0%	99.2%	99.2%	100.0%	100.0%	100.0%	99.2%	98.4%	100.0%
Qureshi	96.0%	99.3%	95.3%	99.3%	99.3%	96.0%	97.3%	94.7%	96.7%
Shepherd	98.3%	100.0%	96.6%	98.3%	98.3%	96.6%	98.3%	96.6%	96.6%
Thomas	98.6%	100.0%	96.1%	99.3%	99.3%	98.9%	97.5%	97.8%	98.6%
Vardiman	93.3%	100.0%	93.3%	93.3%	93.3%	93.3%	100.0%	93.3%	93.3%
SETMA Totals :	98.2%	99.8%	96.9%	99.0%	99.1%	98.0%	98.4%	97.7%	98.3%

Care Transition Audit Publicly reported at www.jameslhollymd.com

Care Transition Audit (Section B)

Discharge Date(s): 01/01/2013 through 04/30/2013

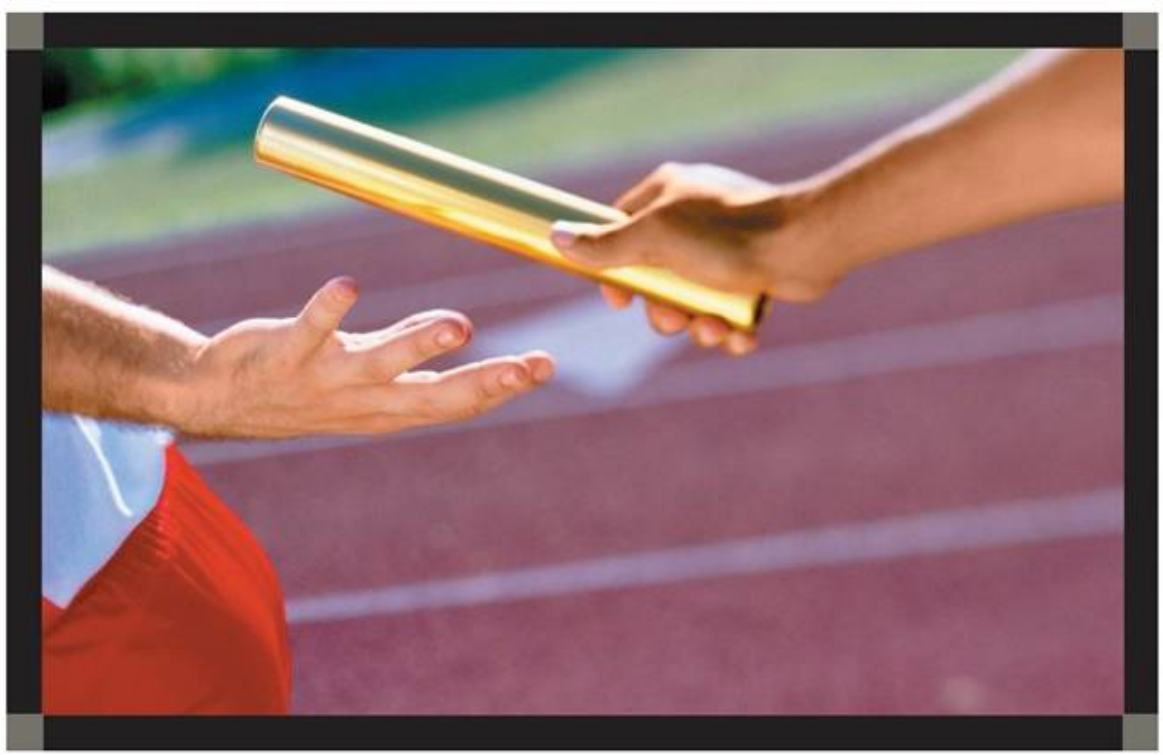
Provider	Advanced Directives	Reason for Discharge	Physical Status	Psychosocial Status	Community Resources Coordinated Referrals	Medication List	Discharge Orders	Follow-Up Instructions	Discharge Materials
Anwar	96.8%	98.7%	98.7%	98.1%	96.2%	95.5%	95.5%	95.5%	92.3%
Aziz	95.3%	98.0%	99.3%	100.0%	97.3%	96.6%	96.6%	96.6%	95.3%
Deiparine, C	95.5%	98.2%	98.8%	98.2%	94.6%	94.3%	94.3%	94.3%	91.7%
Duncan	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	99.0%	99.0%	100.0%	100.0%	99.0%	98.0%	98.0%	98.0%	98.0%
Holly	95.6%	98.8%	98.4%	98.0%	95.2%	95.2%	95.2%	95.2%	94.0%
Le	93.5%	94.6%	100.0%	96.7%	93.5%	94.6%	94.6%	94.6%	94.6%
Leifeste	97.8%	98.2%	99.6%	99.1%	98.2%	98.2%	98.2%	98.2%	90.7%
Murphy	98.6%	98.6%	100.0%	100.0%	98.6%	98.6%	98.6%	98.6%	97.1%
Palang	98.4%	100.0%	100.0%	99.2%	99.2%	98.4%	98.4%	98.4%	96.1%
Qureshi	94.0%	96.7%	99.3%	96.7%	93.3%	93.3%	93.3%	93.3%	90.0%
Shepherd	96.6%	98.3%	98.3%	98.3%	96.6%	96.6%	96.6%	96.6%	94.8%
Thomas	95.7%	98.2%	99.3%	98.6%	97.1%	95.7%	95.7%	95.7%	94.3%
Vardiman	66.7%	93.3%	93.3%	93.3%	80.0%	86.7%	86.7%	86.7%	86.7%
SETMA Totals :	96.0%	98.2%	99.2%	98.5%	96.2%	95.9%	95.9%	95.9%	93.4%

3. Hospital Care Summary & Post-Hospital Plan of Care and Treatment Plan

- At NQF Care Transitions Conference, October, 2010, changed name of "discharge summary."
- Includes follow-up appointments, reconciled medication lists (4 reconciliations: admission, discharge, care coaching call, follow-up appointment), plan of care and treatment plan.
- In last 48 months, completed 16,828 discharges.
- 98.7% of time, document given to patient, hospital, care giver, nursing home, etc., at discharge.
- This is the tool which transfers responsibility for care to the patient. SETMA calls it **the Baton**.

The Baton

This picture is a portrayal of the “plan of care and treatment plan” which is like the “baton” in a relay race. As in the race, if the “baton” is dropped, or if it is not “passed” in the allotted time, no matter how good the members of the team, the race is lost.



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.

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 all 160 examination rooms. 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.

Three Inpatient Batons

- The Hospital Admission Plan of Care
- The Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan
- Post Hospital Plan of Care and Treatment Plan

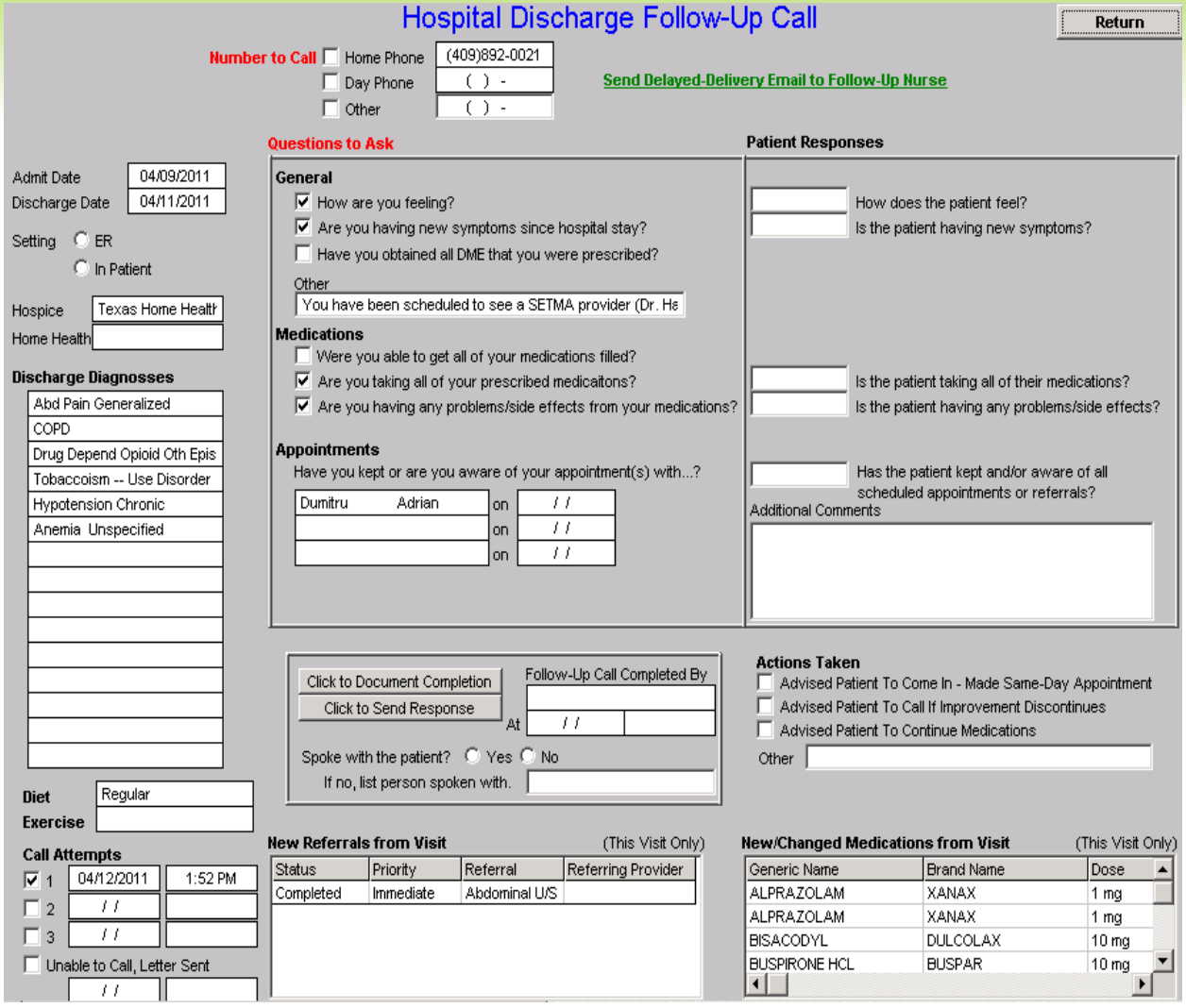
The link below is to de-identified examples of these three documents from a real patient here.

http://www.jameslhollymd.com/Presentations/Transitions-of-Care-Initiative-to-Reduce-Preventable-Readmissions-Institute-for-Healthcare-Improvement

Hospital Follow-Up Call

After the care transition audit is completed and the "baton" document is generated, the provider completes the Hospital-Follow-up-Call template.

All of the data is automatically entered. The provider checks off questions to be asked and additional queries to be made and sends the call request.



Hospital Follow-Up Call

- During the preparation of the “baton” handoff, 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.

4. Hospital Follow-Up Call

A 12-30 minute call made by members of SETMA's Care Coordination Department the day after discharge

- If after three attempts, contact is not made, a letter is automatically generated for mailing to the patient.
- Additional phone calls, or other interventions can be scheduled by the care coordination department
- Results of the follow-up phone call are sent back to the healthcare provider.
- If problems are discovered, immediate appointment is given or other appropriate intervention is initiated, including a home visit.

Hospital Follow-Up Call

- SETMA's Care Coordination Department is currently completing over 3,300 calls to patients monthly. Our analytics shows that the patient receiving or not receiving a care coaching call is one of the key predictors for readmission to the hospital. This includes hospital and clinic follow-up calls, missed appointment calls and follow-up calls generated by the department itself.

- **Monthly, SETMA closes our offices for one-half day** during which time all providers meet for training and review of performance. In those meetings, we have reviewed many IHI papers on Care Transitions.

Hospital Follow-Up Calls

- In the first quarter of 2013, SETMA's Care Coordination department received 1,687 hospital follow-up calls to complete.
- ***All*** calls were completed within one day of discharge.
- Patients discharged on a Friday were called the ***same*** day if they were discharged before 11:30 AM or the next business day if they were discharged after 11:30 AM.

Hospital Follow-Up Calls

The Care Coordination member making the coaching call

- Verifies that the patient is aware of all follow-up appointments
- Verifies that the patient has transportation to keep follow-up appointments and arranges transportation if necessary
- Reviews medications with the patients to ensure patients have started all new medications and stopped any medications which were discontinued
- Ensures the patient has the support system in place to access care

Hospital Follow-Up Calls

- Of the 1,687 follow-up call referrals that were completed in the first quarter of 2013, 556 were for patients considered “high-risk” for readmission.
- Those high-risk patients, each received a ***second*** care coaching within three to five days after the first call.
- They also were placed in a 10-step program described below.

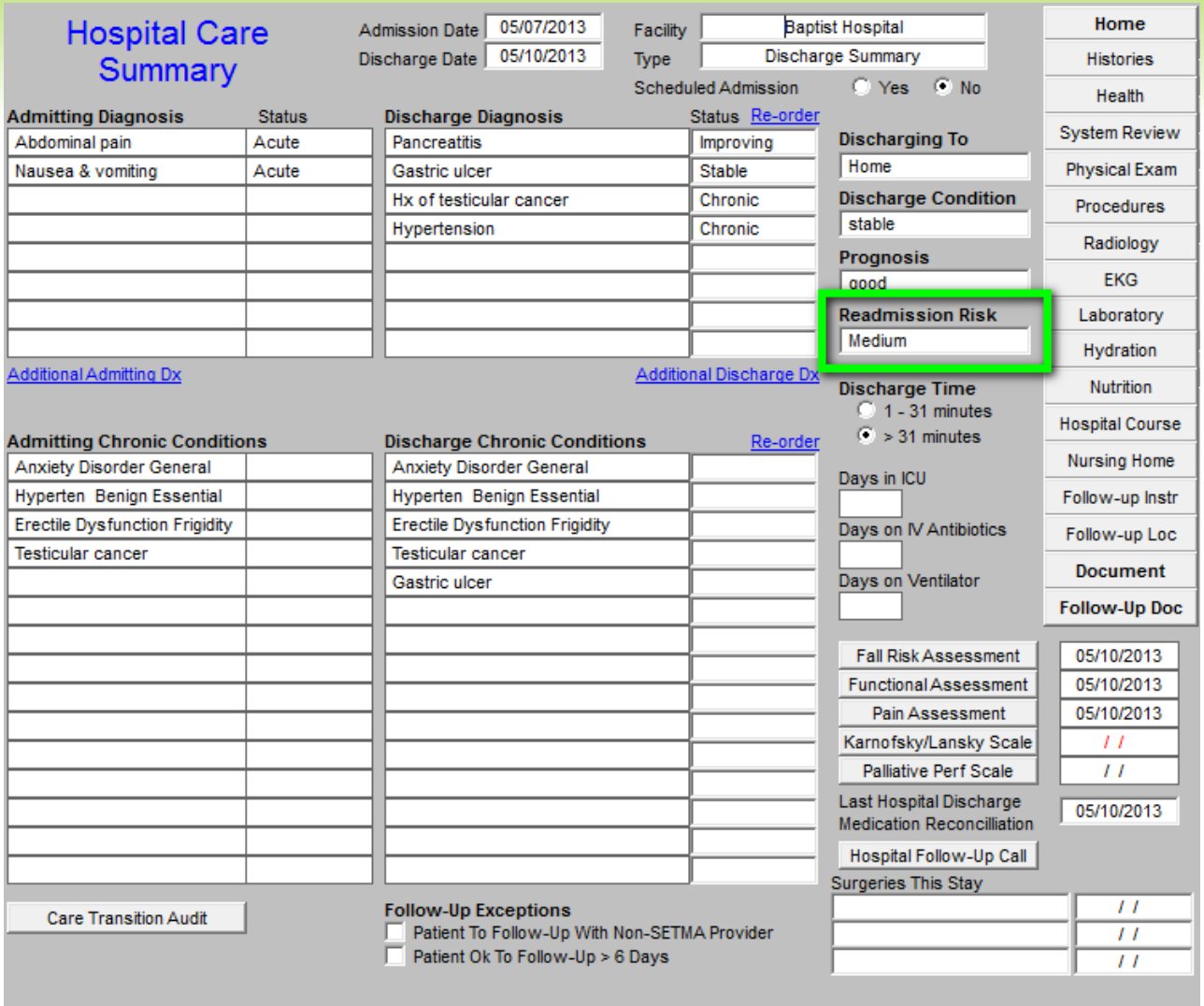
5. Follow-Up Visit with Primary Care Provider

- Care Transition is not complete until the patient is seen by his/her primary care physician within 2-4 days
- If patient misses follow-up appointment they are immediately contacted by Care Coordination. An automated report is prepared daily for all patients missing important visits, including hospital follow-up visits.
- **Two things appear to contribute to improvement in re-hospitalization rates**: coaching call and timely follow-up visit.
- If patient is vulnerable, a call from the primary care physician can be made before the first visit, or an RN or MSW home visit can be made.
- If the appointment was missed due to a barrier to care, the Care Coordination Department can intervene and get the patient seen.

Intermission

If there are any questions about the material we have covered thus far, we can take them now.

Hospital Care Summary Risk of Readmission



Managing High Risk Patients

- When SETMA first began stratifying risk of readmission, we included so many elements, **ALL** patients were determined to be at high risk.
- 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.

Predicting Readmission Risk

We use history of previous hospitalizations to determine a patients risk for readmission.

- High Risk – 2 or more hospitalizations within the previous 12 months
- Medium Risk – 1 hospitalization within the previous 12 months
- Low Risk – No history of hospitalization within the previous 12 months

If necessary, staff can manually elevate the level if they feel a patient has risk factors which place them at a higher risk than designated by the algorithm.

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 two 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.

BI -- Leverage Points

In order to find leverage points for decreasing preventable readmissions, SETMA has deployed a business intelligence software program to contrast and compare patients who are readmitted with those who are not for:

- Age
- Gender
- Diagnoses and co morbidities
- Socio-economic circumstances
- Ethnicity
- Follow-up visit within six days or not
- Care Coaching call completed, etc.

COGNOS (BI) ANALYSIS

Hospital Discharge Analysis

Section I - Admissions and Follow-ups

Prompt Selections

	Selection Group 1	Selection Group 2
Beginning Discharge Date:	Feb 1, 2013	Feb 1, 2013
Ending Discharge Date:	Feb 28, 2013	Feb 28, 2013
Include Readmits:	Within 30 days	Not Within 30 days
Readmission Risk:	Low, Medium, High, Unknown	Low, Medium, High, Unknown
Scheduled Admission:	No, Unknown	No, Unknown
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:	66	327

	Selection Group 1	Selection Group 2
Readmission		
Average Days:	12.76	
Mode:	1.00	
Previous Hospitilization		
Average Days:	5.98	11.40
Mode:	2.00	2.00
Follow-up (Clinic Visit)		
Average Days:	4.85	10.21
Follow-up Visit (%):	40.91%	64.53%
Follow-up (Call)		
Call Completed (%):	90.91%	84.10%
Unable to Complete (%):	10.61%	9.79%

COGNOS (BI) ANALYSIS

Hospital Discharge Analysis

Section II - Patient Measures

Prompt Selections

	Selection Group 1	Selection Group 2
Beginning Discharge Date:	Feb 1, 2013	Feb 1, 2013
Ending Discharge Date:	Feb 28, 2013	Feb 28, 2013
Include Readmits:	Within 30 days	Not Within 30 days
Readmission Risk:	Low, Medium, High, Unknown	Low, Medium, High, Unknown
Scheduled Admission:	No, Unknown	No, Unknown
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:	66	327

Living Alone		
Patient Lives Alone:	13.64%	18.04%
Barriers to Care		
Financial Barriers:	3.03%	3.36%
Social Barriers:	1.52%	4.28%
Assistive Device:	22.73%	11.93%
Habits		
Tobacco Use:	25.76%	27.22%
Alcohol Use:	12.12%	12.84%
Illicit Drug Use:	3.03%	0.61%
Disease - Not in Compliance		
Diabetic:	44.83%	41.73%
Hyperlipidemia:	13.16%	25.51%
Hypertension:	14.81%	19.18%
CHF:	52.00%	65.75%
Care Transition Audit		
Transition Audit Completed:	93.94%	89.91%

COGNOS (BI) ANALYSIS

Hospital Discharge Analysis

Section III - Patient BMI and Changes Made

Prompt Selections

	Selection Group 1	Selection Group 2
Beginning Discharge Date:	Feb 1, 2013	Feb 1, 2013
Ending Discharge Date:	Feb 28, 2013	Feb 28, 2013
Include Readmits:	Within 30 days	Not Within 30 days
Readmission Risk:	Low, Medium, High, Unknown	Low, Medium, High, Unknown
Scheduled Admission:	No, Unknown	No, Unknown
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:	66	327

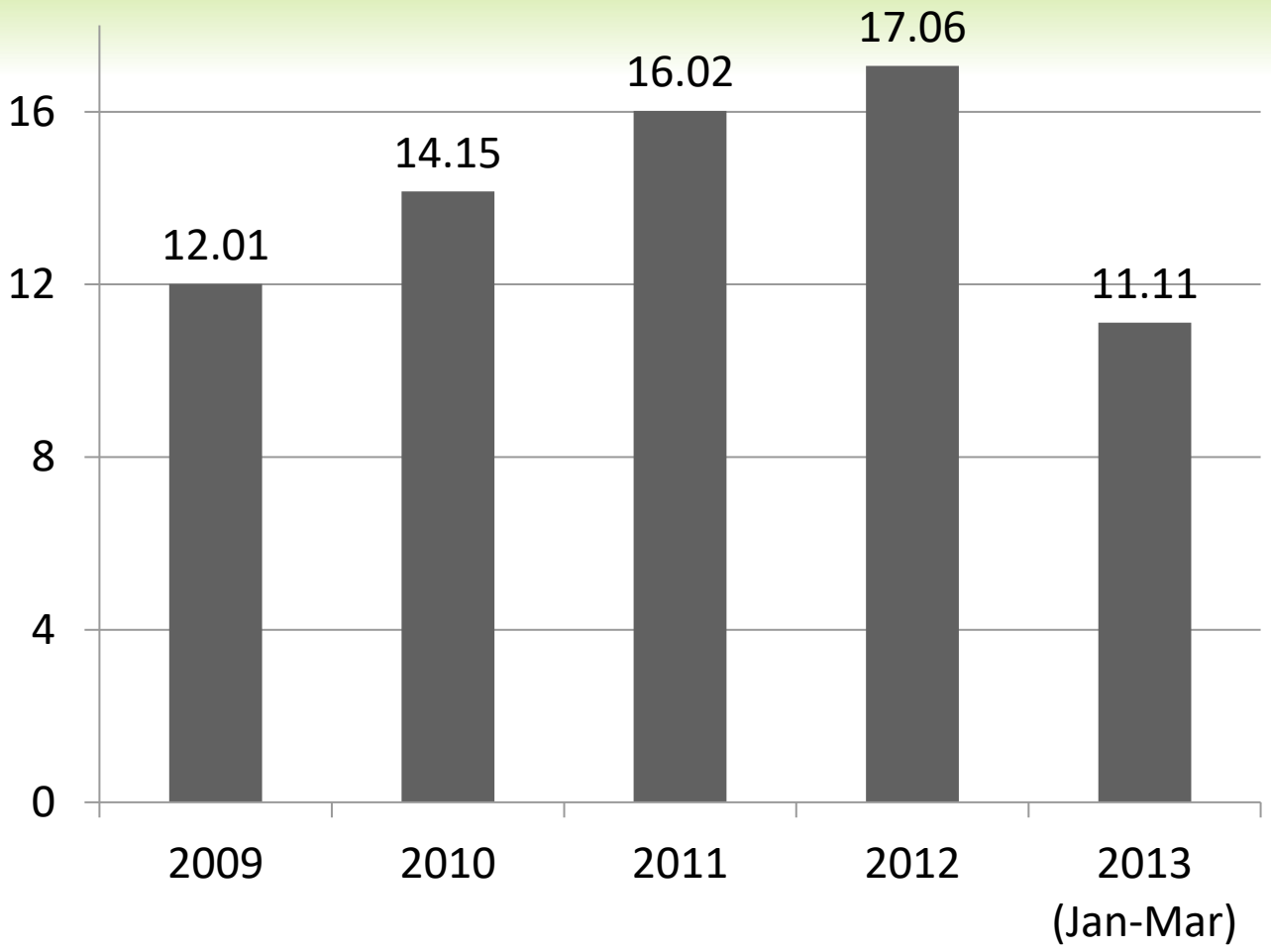
	Selection Group 1	Selection Group 2
Body Mass Index		
Less than 18.5:	9.09%	4.89%
Between 18.5 and 25:	27.27%	22.63%
Between 25 and 30:	13.64%	23.24%
Between 30 and 35:	10.61%	19.27%
Between 35 and 40:	18.18%	9.17%
Greater than 40:	13.64%	11.62%

SETMA & Baptist Hospital

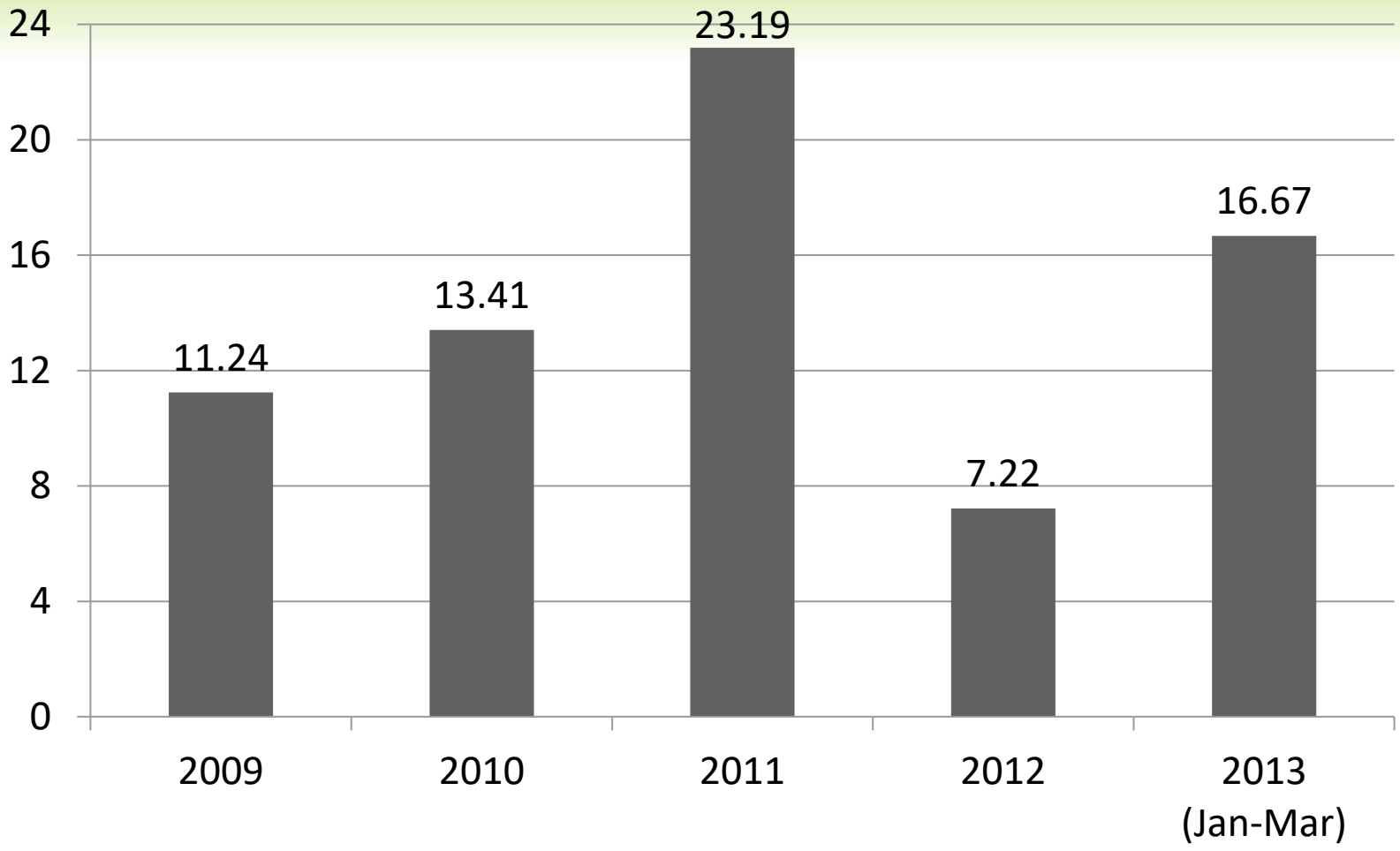
- At any given time, SETMA manages 20-40% of the inpatient census at Baptist Hospital.
- The average daily census for Baptist Hospital is 250-300 patients.
- In addition to managing the patients assigned to us, we also care for 25% of the indigent, uninsured and unassigned patients in Baptist Hospital.

30-Day Readmission Rates Any DRG

In 2009, SETMA began taking care of 25% of the uninsured and indigent patients admitted to Baptist Hospital. The complexity of transitions of care in this group caused an increase in readmissions. Hopefully, we have solved this.

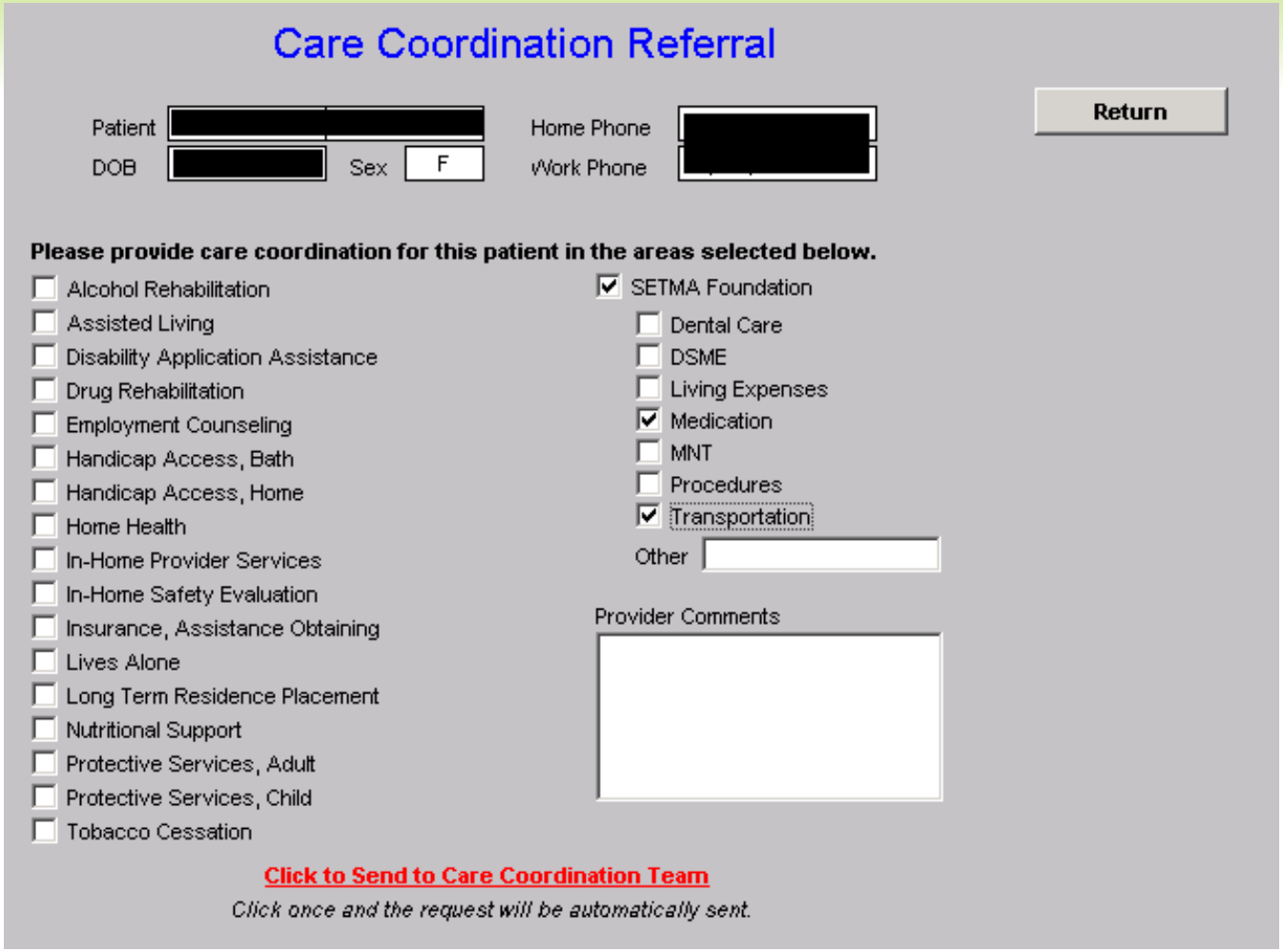


30-Day Readmission Rates PN, Any DRG



30-Day Readmission Rates PN, FFS Medicare

Care Coordination Referral



SETMA Foundation

- Under the Medical Home model the provider has NOT done his/her job when he/she simply prescribes the care which meets national standards. **Doing the job of Medical Home requires the prescribing of the best care which is available and accessible to the patient, and when that care is less than the best, the provider makes every attempt to find resources to help that patient obtain the care needed**.

SETMA Foundation

- Because we treat such a vulnerable population, in 2008, SETMA established the SETMA Foundation. Thus far, the SETMA partners have contributed $2,000,000 to the Foundation. These funds cannot profit SETMA and can only be used to pay for the care of our patients by providers who will not see them without being paid. SETMA treats all of these patients at no cost.

SETMA Foundation PC-MH Poster Child

- In February 2009, SETMA saw a patient who has a very complex healthcare needs. When seen in the hospital as a new patient, he was angry, bitter and hostile. No amount of cajoling would change the patient's demeanor.

- During his hospital follow-up, it was discovered that the patient was only taking four of nine medications because of expense; could not afford gas to come to the doctor; was going blind but did not have the money to see an eye specialist; could not afford the co-pays for diabetes education and could not work but did not know how to apply for disability. He also was uninsured.

SETMA Foundation

He left after the hospital follow-up visit with the Foundation providing:

1. All of his medications. The Foundation has continued to do so for the past four years at a cost of $2,200 a quarter.
2. A gas card so that he could afford to come to multiple visits for education and other health needs.
3. Waiver of cost for SETMA's ADA accredited Diabetes Self-Management Education and Medical Nutrition Therapy programs.
4. Appointment to an experimental, vision-preservation program.
5. Assistance with applying for disability. Which he received after four months. Three years later his Medicare became active.

SETMA Foundation

- Are gas cards, disability applications, paying for medications a part of a physician's responsibilities? Absolutely not; but, are they a part of Medical Home? Absolutely! This patient, who was depressed and glum in the hospital, such that no one wanted to go into the patient's room, left the office with help.
- He returned six-weeks later with a smile and with **hope,** which may be that the biggest result of Medical Home. Without hope patients will not make changes.
- His diabetes was treated to goal for the first time in ten years. He has remained treated to goal for the past four years.

SETMA Foundation

Every healthcare provider doesn't have a foundation and even ours can't meet everyone's needs, but assisting patients in finding the resources to support their health is a part of medical home.

SETMA Foundation

- And, when those resources cannot be found, Medical Home will be “done” by modifying the treatment plan so that what is prescribed can be obtained.
- The ordering of tests, treatments, prescriptions which we know our patients cannot obtain is not healthcare, even if the plan of care is up to national standards.

Infrastructure for success

- With this infrastructure
- With this care coordination
- With this continuity of care
- With these patient support functions

SETMA is ready to make a major effort to decrease preventable readmissions to the hospital.

Care Transitions & Hospital Readmissions

- **For14 years, we have focused on processes, believing that outcomes will inevitably follow, which outcomes will then inevitably be sustainable.**
- SETMA expects to significantly affect hospital preventable re-admission rates over the next two years and to sustain those improvements.
- Supported by care transitions, coordination of care, medication reconciliation (at multiple points of care) patient safety, quality of care and cost of care will be positively impacted.

Conclusions

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.

Conclusions

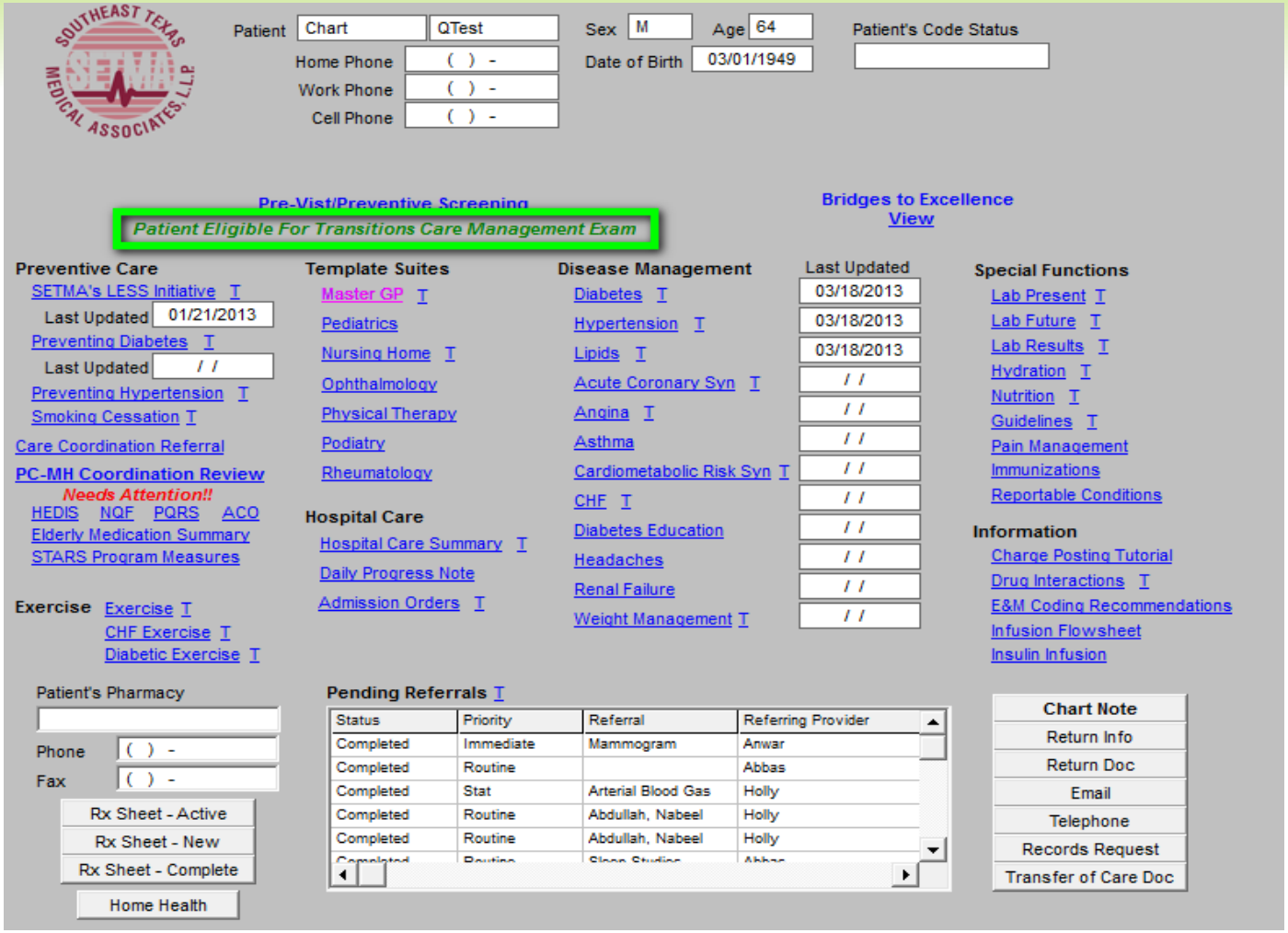
4. The problem will be solved by more contact with the patient and/or care giver in the home: home health, social worker, provider house calls.
5. The problem will be solved by the patient and/or care giver having more contact electronically (telephone, e-mail, web portal, cell phone) with the patient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

Care Transitions Management Codes

- In January, 2013, CMS published two Transitions of Care Management Codes which were adopted 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.
- In order to determine which of the Transitions of Care Management Codes to use, the healthcare provider must distinguish between a Moderately Complex visit and a High Complex visit. SETMA assumes that the complexity discriminator refers to the E&M codes for 99214 and 99215, in which case it would generally be possible in the ambulatory setting for a provider only to use the lower of the TCM codes, i.e., 99495.

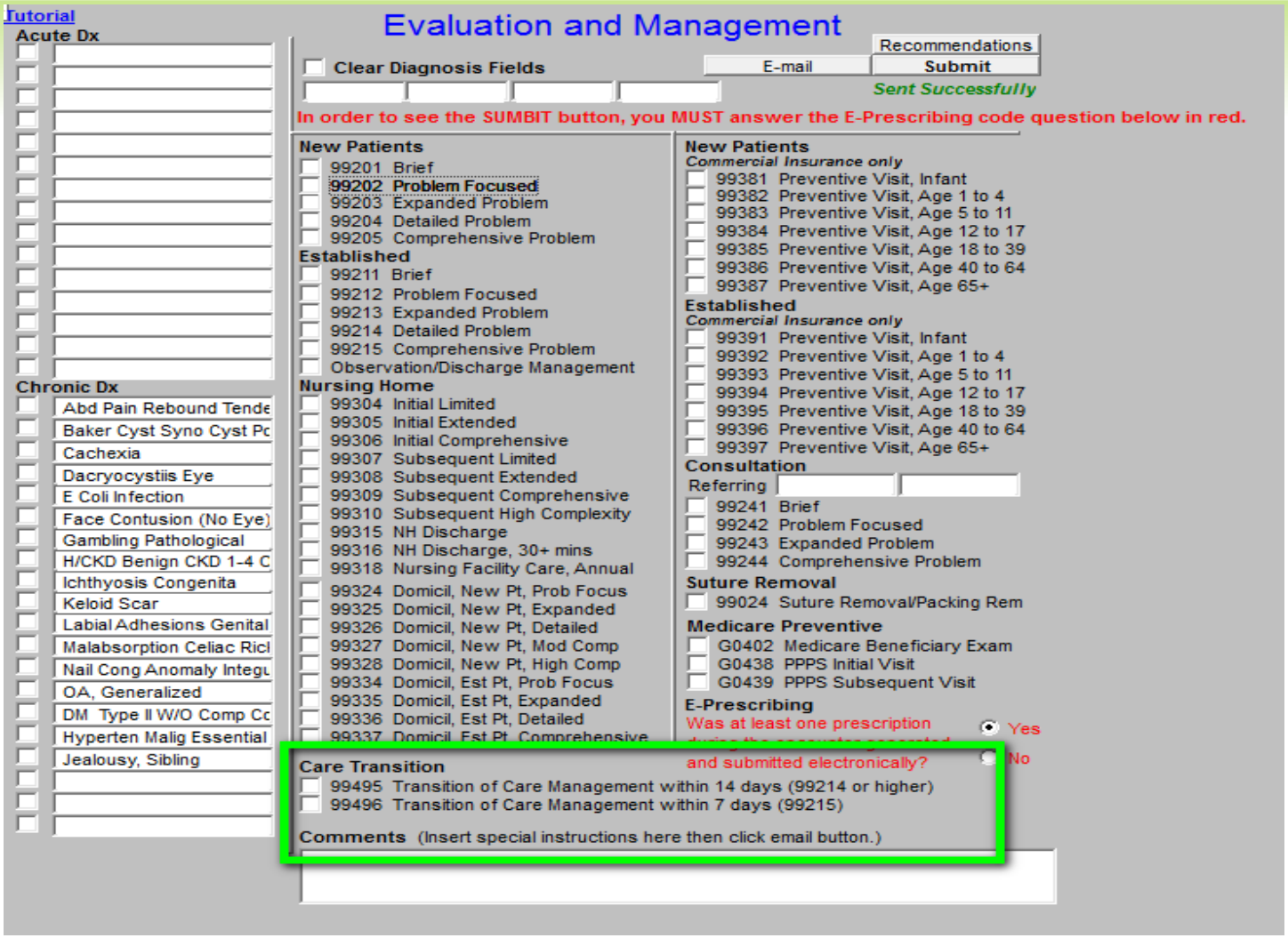
Care Transitions Management Codes

When a patient is seen at SETMA who has been discharged from the hospital, a note automatically appears on the AAA Home Template, indicating that the patient is eligible for a Transitions of Care Management evaluation.



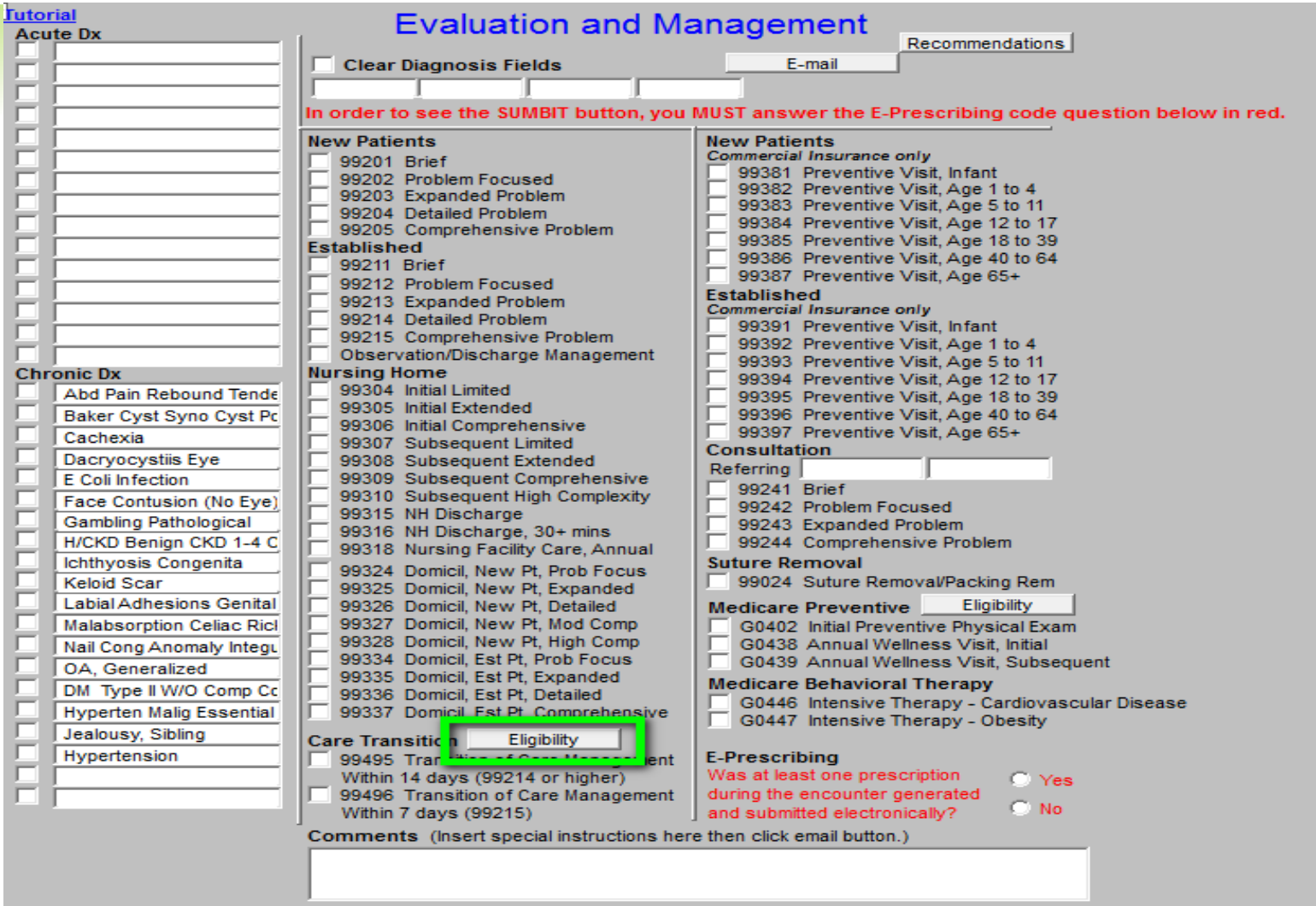
Care Transitions Management Codes

The Transitions of Care Management Codes (TMC Codes) have been added to SETMA's E&M Template (see below outlined in **green**.



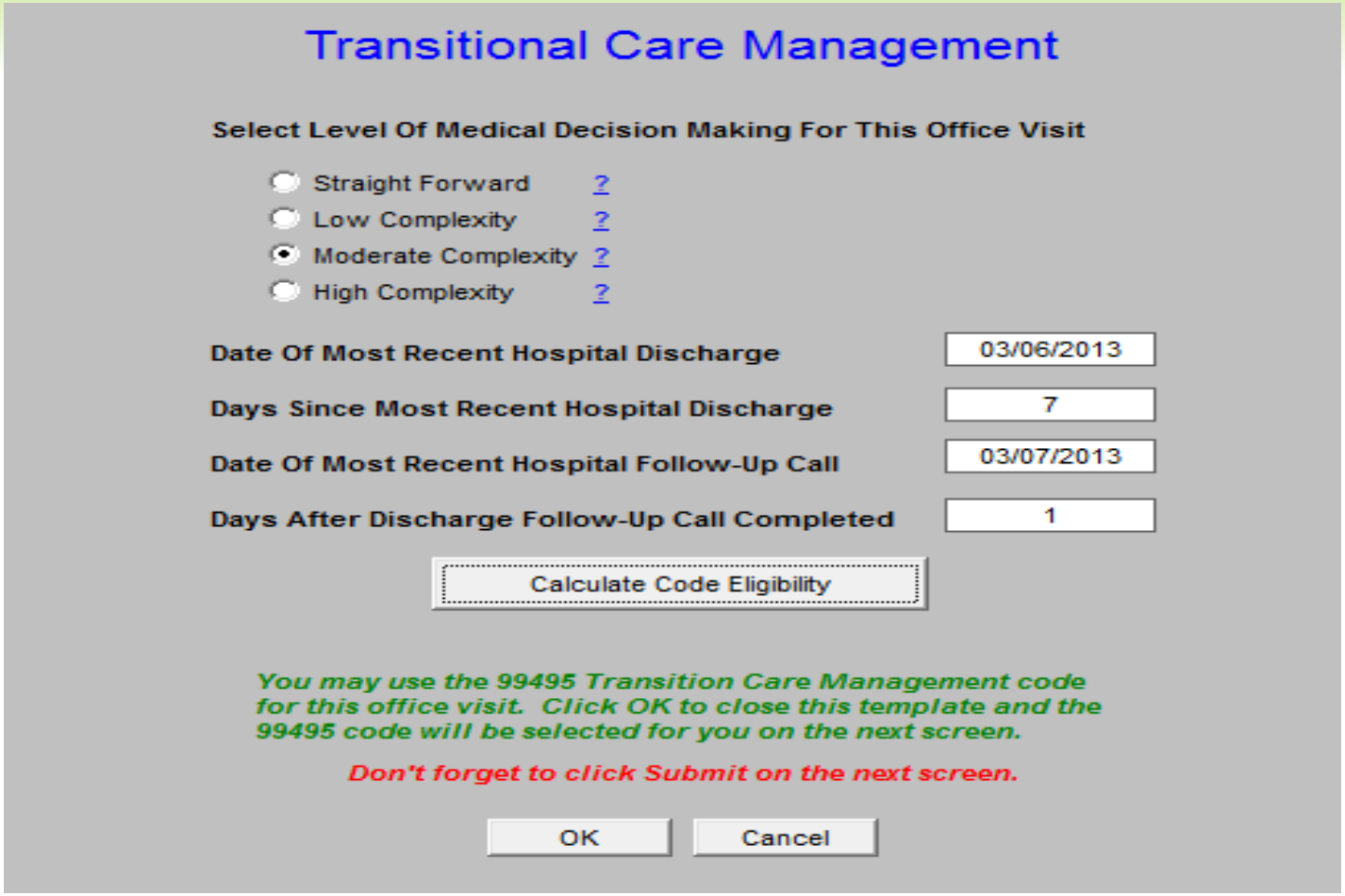
Care Transitions Management Codes

As seen in the template to the right. SETMA has added a button entitled "Eligibility."



Care Transitions Management Codes

When the "eligibility" button is deployed, it will display this template.



Care Transitions Management Codes

The eligibility template aggregates the information required for determining if you have qualified for one of the TCM Codes and if you have, which one. The functionality in the background of the template will search to see if the following requirements have been met:

a. The patient is being seen in 7 or 14 days from discharge
b. The patient's visit qualifies for a 99214 or a 99215
c. The patient had a contact within two days of being discharged
d. Medication reconciliation was done after the hospital discharge
e. Plan of Care and Treatment Plan was given to the patient and/or care giver

Care Transitions Management Codes

- When you click “Eligibility,” you will need to establish the complexity of the visit by clicking in the radial button next to the Complexity of the visit, i.e., moderate or high. If you have already selected the Complexity of Decision making level on the E&M template, you simply click on the “Calculate Code Eligibility” button and the appropriate TCM code will be selected.

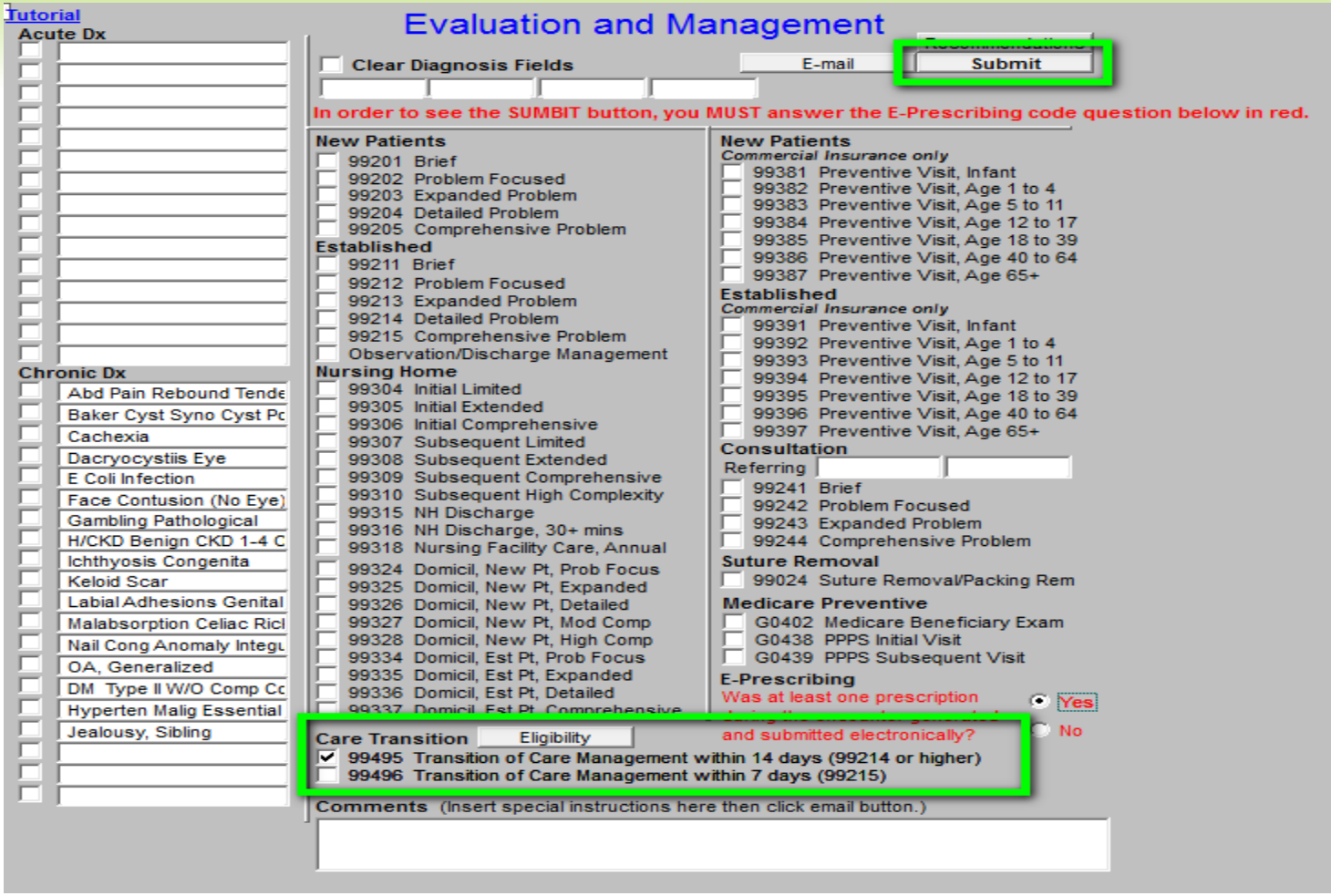
- A detailed explanation of this process can be found at www.jameslhollymd.com at the following link:

http://www.jameslhollymd.com/epm-tools/transition-of-care-management-code-tutorial

Care Transitions Management Codes

When all of the standards are met, the correct code will automatically be check.

When you complete the steps above don't forget to click the "Submit" button. See "submit" to the right in Green



Questions

Please feel free to ask any questions you may have.

You are welcome to contact Dr. Holly at jholly@jameslhollymd.com or at (409) 654-6819

Appendix

- Slides 62-67 – HI concepts presented earlier in this presentation.
- Slides 68-73 – Additional detail on SETMA's view of the "baton."
- Slides 74-80 – IHI concepts on Transitions of Care from Inpatient to Ambulatory Care.

Institute for Healthcare Improvement

In October, 2007, **IHI** published the **Triple Aim** which includes the "simultaneous pursuit of:

1. "Improving the experience of care
2. "Improving the health of populations
3. "Reducing per capita costs of health care"

Redesign of Primary Care Services and Structures

"(Included)…(five) components which would contribute to fulfilling the **Triple Aim**:

1. "Focus on individuals and families
2. ***"Redesign of primary care services and structures***
3. "Population health management
4. "Cost control platform
5. "System integration & execution"

(http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/Approach.aspx)

Institute for Healthcare Improvement

- "Triple Aim is a framework for partnering with local government agencies, social service organizations, health plans, faith groups, and other community stakeholders to achieve three powerful goals simultaneously…

- "(IHI's)…program is ideal for **change agents** in health related organizations who are responsible for developing strategy, delivering front-line care, or crafting policy for a specific population."

The Triple Aim

"Preconditions for the Triple Aim include:

1. "Enrollment of Identified population
2. "A commitment to universality for its members
3. "The existence of an organization, an '**integrator'** that accepts responsibility for all three aims for that population."

Donald M. Berwick, Thomas W. Nolan and John Whittington
Health Affairs May 2008 vol. 27 no. 3 759-769

The Triple Aim

The Triple Aim and the Moral Test of Government:

"The moral test of government is how it treats those who are In the dawn of life, the children; those who are in the twilight of life, the aged; and those in the shadows of life, the sick, the needy and the handicapped." (November 4, 1977, Senator Humphrey, Inscribed on the entrance of the Hubert Humphrey building, HHS Headquarters)

Donald Berwick, "The Moral Test"
Keynote Presentation, December 7, 2011
IHI 23rd Annual National Forum on
Quality Improvement in Health Care

Are You Ready To Be An *Integrator*?

From the healthcare provider's perspective, the following are **Triple Aim *Integrators***:

- Medicare Advantage
- Medical Home
- Accountable Care Organizations

Each of these "structures" requires primary care redesign in order to be successful.

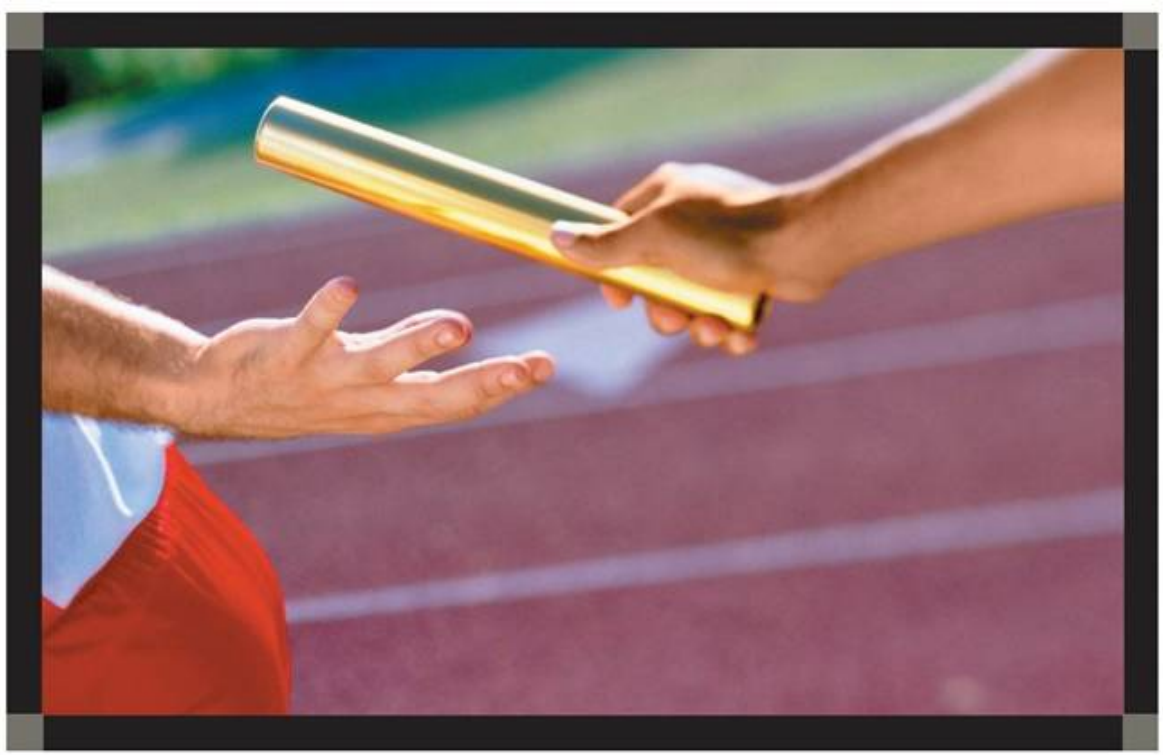
SETMA's Model of Care

The **Redesign of Primary Care Services and Structures** requires that "Basic health care services are provided by a variety of professions: doctors, nurses, mental health clinicians, nutritionists, pharmacists, and others." The steps to this redesign requires that the primary care "integrator":

A. **"Have a team** for basic services that can deliver at least 70% of the necessary medical and health-related social services to the population.
B. **"Deliberately build an access** platform for maximum flexibility to provide customized health care for the needs of patients, families, and providers.
C. **"Cooperate and coordinate** with other specialties, hospitals, and community services related to health." (IHI)

The Baton

This picture is a portrayal of the “plan of care and treatment plan” which is like the “baton” in a relay race. As in the race, if the “baton” is dropped, or if it is not “passed” in the allotted time, no matter how good the members of the team, the race is lost.



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.

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.

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.

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.**

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.

IHI Reference

- Rutherford P, Nielsen GA, Taylor J, Bradke P, Coleman E. ***How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Re-hospitalizations***. Cambridge, MA: Institute for Healthcare Improvement; June 2012.
- Available at www.IHI.org

Improved Transition & Reception

Institute for Healthcare Improvement

- "An improved transition out of the hospital (and from post-acute care and rehabilitation facilities) as well as…
- "An **activated and reliable reception** into the next setting of care such as a primary care practice, home health care agency, or a skilled nursing facility."

Activated Receivers

- An **example of an activated receiver is a physician‘s office** with a specified process for scheduling post-hospital follow-up visits within 2 to 4 days of discharge.
- “Although the care that prevents re-hospitalization occurs largely outside of the hospital, it starts in the hospital.”

Key Changes to Improve Transitions

Perform an Enhanced Assessment of Post-Hospital Needs

A. "Involve the patient, family caregiver(s), and community provider(s) as full partners in completing a needs assessment of the patient's home-going needs.
B. "Reconcile medications upon admission.
C. "Create a customized discharge plan based on the assessment."

Key Changes to Improve Transitions

Ensure Post-Hospital Care Follow-Up

A. "Assess the patient's medical and social risk for readmission and finalize the customized discharge plan.

B. "Prior to discharge, schedule timely follow-up care and initiate clinical and social services as indicated from the assessment of post-hospital needs and the capabilities of patients and family caregivers."

Key Changes to Improve Transitions

Provide Real-Time Handover Communications

A. "Give patient and family members a patient-friendly post-hospital care plan that includes a clear medication list.
B. "Provide customized, real-time critical information to the next clinical care provider(s).
C. "For high-risk patients, a clinician calls the individual(s) listed as the patient's next clinical care provider(s) to discuss the patient's status and plan of care."

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
- African American Race
- Inpatient use of narcotics
- Inpatient use of corticosteroids
- Cancer with and without metastasis
- Renal Failure
- Congestive Heart Failure
- Weight loss