

***SETMA'S TRANSITIONS OF CARE  
INITIATIVE TO REDUCE  
PREVENTABLE READMISSIONS***

**INSTITUTE FOR HEALTHCARE IMPROVEMENT  
STAAR -- SHINING THE SPOTLIGHT CALL  
*MAY 31, 2013***

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# 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](http://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		OK	Cancel
Has the reason for hospitalization been documented?	Yes	Click to Update/Review	
Have discharge diagnoses been entered?	Yes	Click to Update/Review	
Have the patient's medications been updated/reconciled?	Yes	Click to Update/Review	
Have the patient's allergies been updated? Also document allergies/reactions to medications.	Yes	Click to Update/Review	
Has the patient's cognitive status been documented?	Yes	Click to Update/Review	
Have pending results or tests been documented?	Yes	Click to Update/Review	
Have major procedures been documented?	Yes	Click to Update/Review	
Has a follow-up care plan been completed?	Yes	Click to Update/Review	
Has the patient's progress to goals/treatment been documented?	Yes	Click to Update/Review	
Have advanced directives been completed and a surrogate decision maker named or a reason given for not completing an advanced care plan?	Yes	Click to Update/Review	
Has the reason for discharge been documented?	Yes	Click to Update/Review	
Has the patient's physical status been documented?	Yes	Click to Update/Review	
Has the patient's psychosocial status been documented?	Yes	Click to Update/Review	
Has a list of available community resources been documented?	Yes	Click to Update/Review	
--OR--			
Has a list of coordinated referrals been documented?	No	Click to Update/Review	
Has a follow-up call been scheduled?	Yes	Click to Update/Review	

# CARE TRANSITION AUDIT

Has the current/reconciled medication list been discussed with the patient/family/caregiver?

Yes  No

Have the discharge orders been discussed with the patient/family/caregiver?

Yes  No

Have the follow-up instructions been discussed with the patient/family/caregiver?

Yes  No

Have the discharge materials been printed and given to the patient/family/caregiver?

Yes  No

Brandon Sheehan	
11/23/2011	10:05 AM
Brandon Sheehan	
11/23/2011	10:05 AM
Brandon Sheehan	
11/23/2011	10:05 AM
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](http://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%
<b>SETMA Totals :</b>	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](http://WWW.JAMESLHOLLYMD.COM)



## Care Transition Audit (Section B)

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

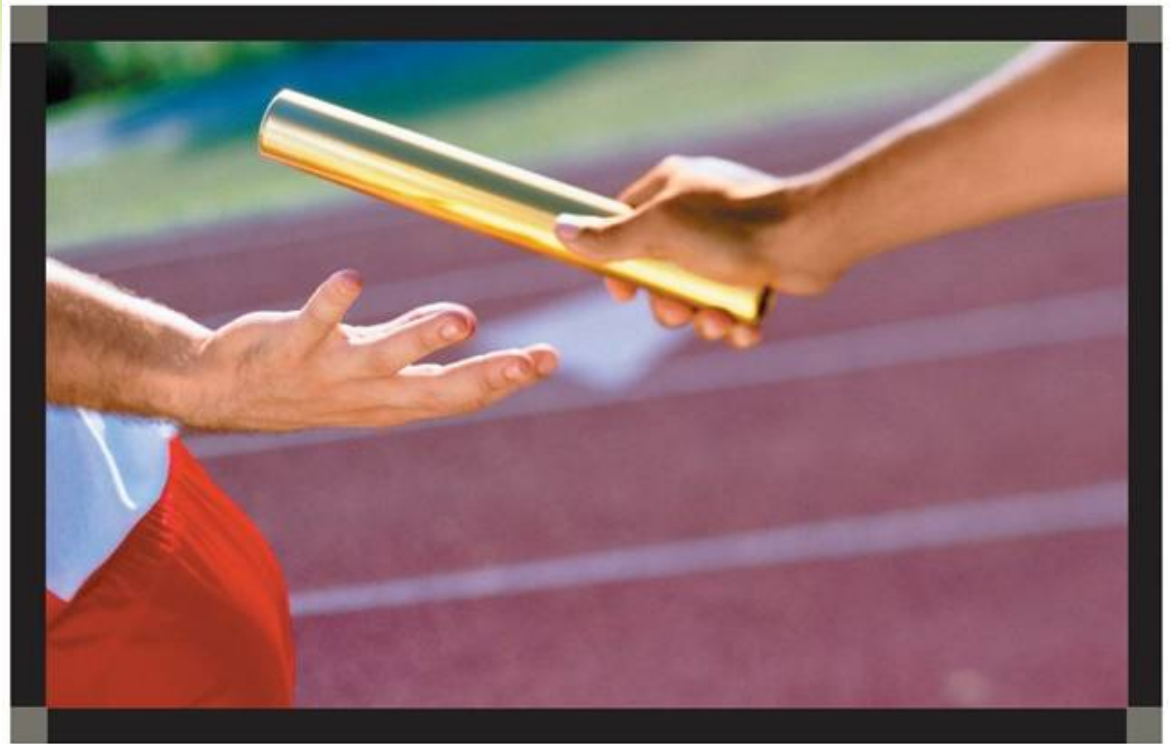
Provider	Advanced Directives	Reason for Discharge	Physical Status	Psychosocial Status	Community Resources Coordinated Referrals	Medication List	Discharge Orders	Follow-Up Instructions	Discharge Materials
Anwar	96.8%	98.7%	98.7%	98.1%	96.2%	95.5%	95.5%	95.5%	92.3%
Aziz	95.3%	98.0%	99.3%	100.0%	97.3%	96.6%	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%
<b>SETMA Totals :</b>	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

- 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

### Hospital Care Summary

Admission Date  Facility

Discharge Date  Type

Scheduled Admission  Yes  No

**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

Admitting Diagnosis	Status	Discharge Diagnosis	Status
Abdominal pain	Acute	Pancreatitis	Improving
Nausea & vomiting	Acute	Gastric ulcer	Stable
		Hx of testicular cancer	Chronic
		Hypertension	Chronic

Discharge Diagnosis	Status
Pancreatitis	Improving
Gastric ulcer	Stable
Hx of testicular cancer	Chronic
Hypertension	Chronic

**Discharging To**

**Discharge Condition**

**Prognosis**

**Readmission Risk**

[Additional Admitting Dx](#)

[Additional Discharge Dx](#)

Admitting Chronic Conditions	Discharge Chronic Conditions
Anxiety Disorder General	Anxiety Disorder General
Hyperten Benign Essential	Hyperten Benign Essential
Erectile Dysfunction Frigidity	Erectile Dysfunction Frigidity
Testicular cancer	Testicular cancer
	Gastric ulcer

Discharge Chronic Conditions	Status
Anxiety Disorder General	
Hyperten Benign Essential	
Erectile Dysfunction Frigidity	
Testicular cancer	
Gastric ulcer	

**Discharge Time**  
 1 - 31 minutes  
 > 31 minutes

Days in ICU

Days on IV Antibiotics

Days on Ventilator

Fall Risk Assessment	05/10/2013
Functional Assessment	05/10/2013
Pain Assessment	05/10/2013
Karnofsky/Lansky Scale	//
Palliative Perf Scale	//
Last Hospital Discharge Medication Reconciliation	05/10/2013
Hospital Follow-Up Call	
Surgeries This Stay	//
	//
	//

Care Transition Audit

**Follow-Up Exceptions**

Patient To Follow-Up With Non-SETMA Provider

Patient Ok To Follow-Up > 6 Days

# 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 patient's 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

<b>Prompt Selections</b>		
	<u>Selection Group 1</u>	<u>Selection Group 2</u>
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

	<u>Selection Group 1</u>	<u>Selection Group 2</u>
<b>Readmission</b>		
Average Days:	12.76	
Mode:	1.00	
<b>Previous Hospitalization</b>		
Average Days:	5.98	11.40
Mode:	2.00	2.00
<b>Follow-up (Clinic Visit)</b>		
Average Days:	4.85	10.21
Follow-up Visit (%):	40.91%	64.53%
<b>Follow-up (Call)</b>		
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

	<u>Selection Group 1</u>	<u>Selection Group 2</u>
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%
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#### 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%
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# COGNOS (BI) ANALYSIS



## Hospital Discharge Analysis

### Section III - Patient BMI and Changes Made

<b>Prompt Selections</b>		
	<u>Selection Group 1</u>	<u>Selection Group 2</u>
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

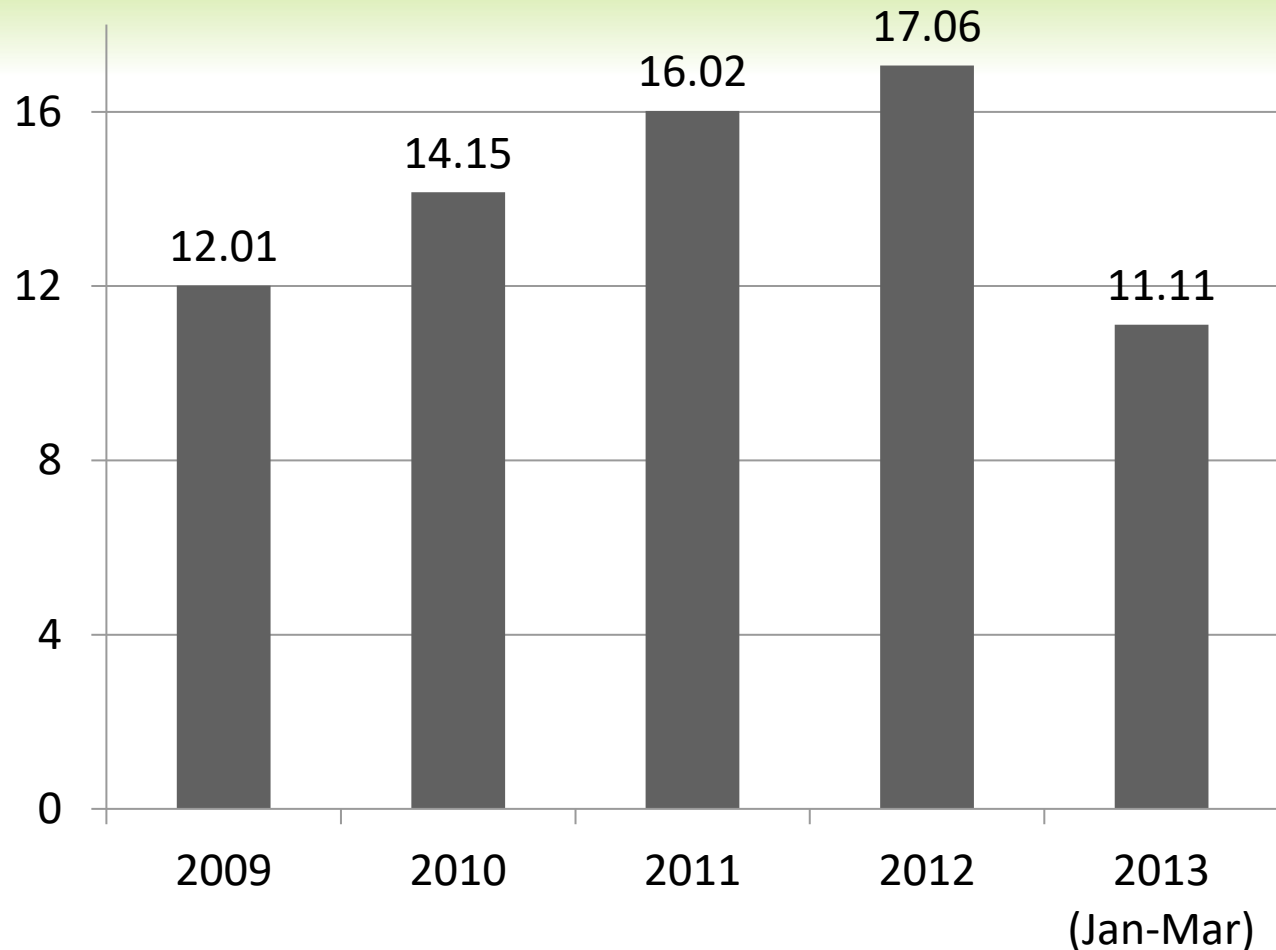
Less than 18.5:	9.09%	4.89%
Between 18.5 and 25:	27.27%	22.63%
Between 25 and 30:	13.64%	23.24%
Between 30 and 35:	10.61%	19.27%
Between 35 and 40:	18.18%	9.17%
Greater than 40:	13.64%	11.62%

# SETMA & BAPTIST HOSPITAL

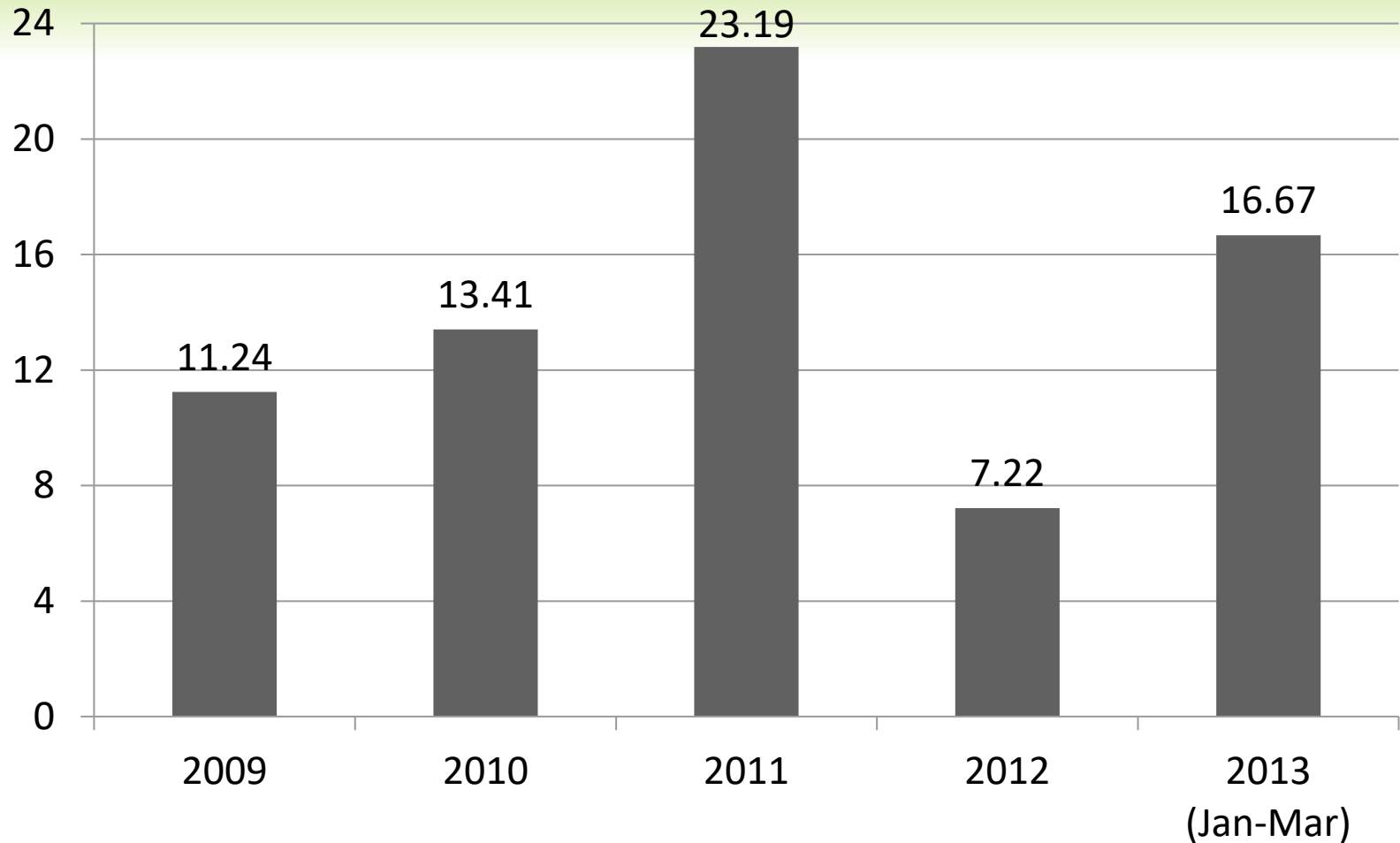
- At any given time, SETMA manages 20-40% of the inpatient census at Baptist Hospital.
- The average daily census for Baptist Hospital is 250-300 patients.
- In addition to managing the patients assigned to us, we also care for 25% of the indigent, uninsured and unassigned patients in Baptist Hospital.

# 30-DAY READMISSION RATES ANY DRG

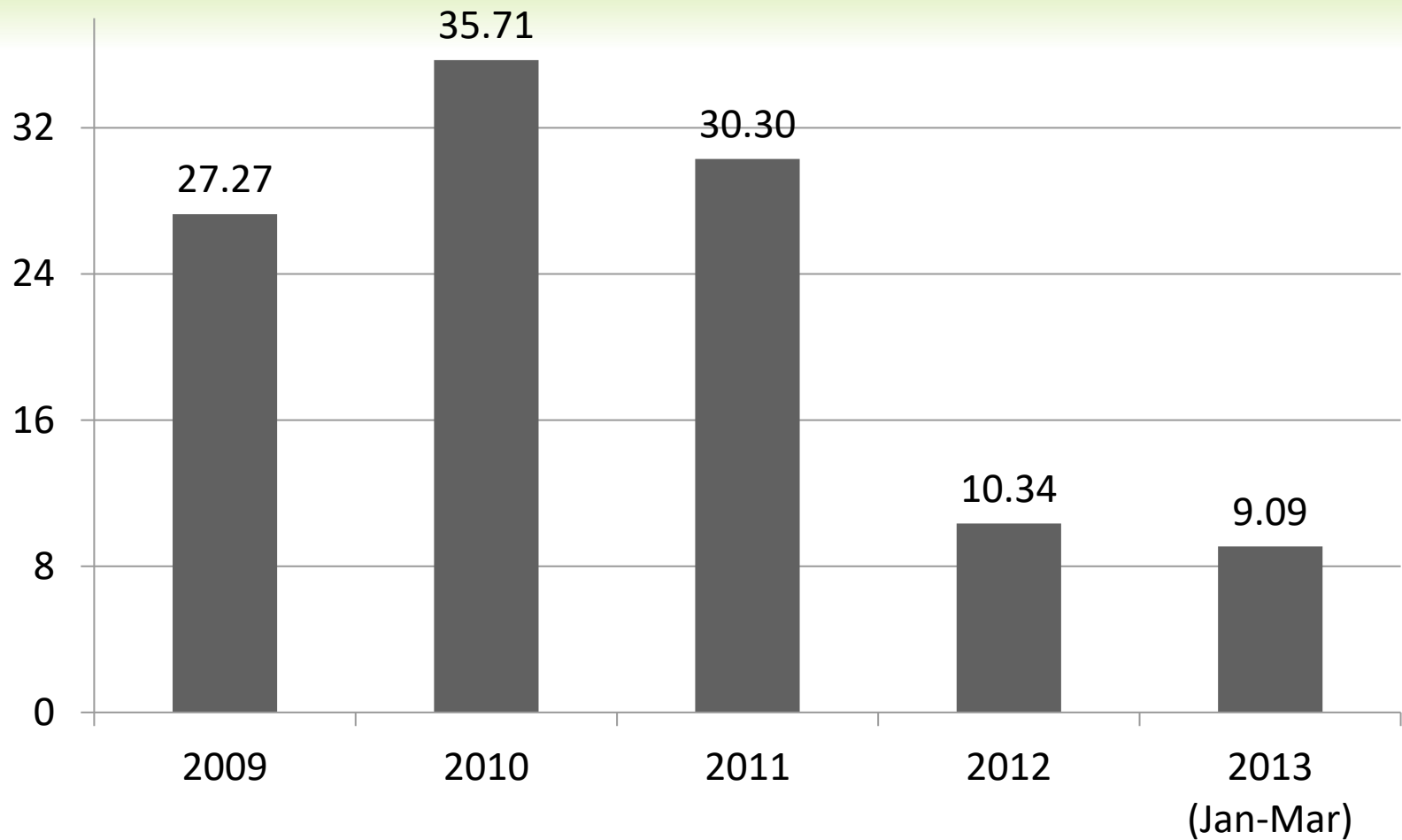
In 2009, SETMA began taking care of 25% of the uninsured and indigent patients admitted to Baptist Hospital. The complexity of transitions of care in this group caused an increase in readmissions. Hopefully, we have solved this.



# 30-DAY READMISSION RATES PN, ANY DRG



# 30-DAY READMISSION RATES PN, FFS MEDICARE





# CARE COORDINATION REFERRAL

## Care Coordination Referral

Patient   
 DOB  Sex

Home Phone   
 Work Phone

[Return](#)

**Please provide care coordination for this patient in the areas selected below.**

- |  |  |
|--|--|
| <input type="checkbox"/> Alcohol Rehabilitation            | <input checked="" type="checkbox"/> SETMA Foundation |
| <input type="checkbox"/> Assisted Living                   | <input type="checkbox"/> Dental Care                 |
| <input type="checkbox"/> Disability Application Assistance | <input type="checkbox"/> DSME                        |
| <input type="checkbox"/> Drug Rehabilitation               | <input type="checkbox"/> Living Expenses             |
| <input type="checkbox"/> Employment Counseling             | <input checked="" type="checkbox"/> Medication       |
| <input type="checkbox"/> Handicap Access, Bath             | <input type="checkbox"/> MNT                         |
| <input type="checkbox"/> Handicap Access, Home             | <input type="checkbox"/> Procedures                  |
| <input type="checkbox"/> Home Health                       | <input checked="" type="checkbox"/> Transportation   |
| <input type="checkbox"/> In-Home Provider Services         | Other <input type="text"/>                           |
| <input type="checkbox"/> In-Home Safety Evaluation         |  |
| <input type="checkbox"/> Insurance, Assistance Obtaining   | Provider Comments                                    |
| <input type="checkbox"/> Lives Alone                       | <input type="text"/>                                 |
| <input type="checkbox"/> Long Term Residence Placement     |  |
| <input type="checkbox"/> Nutritional Support               |  |
| <input type="checkbox"/> Protective Services, Adult        |  |
| <input type="checkbox"/> Protective Services, Child        |  |
| <input type="checkbox"/> Tobacco Cessation                 |  |

**[Click to Send to Care Coordination Team](#)**

*Click once and the request will be automatically sent.*

# 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

- **For 14 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.

**SOUTHEAST TEXAS  
SETMA  
MEDICAL ASSOCIATES, L.L.P.**

Patient Chart: [ ] QTest: [ ] Sex: M Age: 64 Patient's Code Status: [ ]  
 Home Phone: ( ) - [ ] Date of Birth: 03/01/1949  
 Work Phone: ( ) - [ ]  
 Cell Phone: ( ) - [ ]

**Pre-Vist/Preventive Screening**  
**Patient Eligible For Transitions Care Management Exam**

**Bridges to Excellence**  
[View](#)

Preventive Care	Template Suites	Disease Management	Last Updated	Special Functions																												
<a href="#">SETMA's LESS Initiative</a> I Last Updated: 01/21/2013	<a href="#">Master GP</a> I <a href="#">Pediatrics</a> <a href="#">Nursing Home</a> I <a href="#">Ophthalmology</a> <a href="#">Physical Therapy</a> <a href="#">Podiatry</a> <a href="#">Rheumatology</a>	<a href="#">Diabetes</a> I <a href="#">Hypertension</a> I <a href="#">Lipids</a> I <a href="#">Acute Coronary Syn</a> I <a href="#">Angina</a> I <a href="#">Asthma</a> <a href="#">Cardiometabolic Risk Syn</a> I <a href="#">CHF</a> I <a href="#">Diabetes Education</a> <a href="#">Headaches</a> <a href="#">Renal Failure</a> <a href="#">Weight Management</a> I	03/18/2013 03/18/2013 03/18/2013 // // // // // // // // //	<a href="#">Lab Present</a> I <a href="#">Lab Future</a> I <a href="#">Lab Results</a> I <a href="#">Hydration</a> I <a href="#">Nutrition</a> I <a href="#">Guidelines</a> I <a href="#">Pain Management</a> <a href="#">Immunizations</a> <a href="#">Reportable Conditions</a>																												
<a href="#">Preventing Diabetes</a> I Last Updated: //	<b>Hospital Care</b> <a href="#">Hospital Care Summary</a> I <a href="#">Daily Progress Note</a> <a href="#">Admission Orders</a> I			<b>Information</b> <a href="#">Charge Posting Tutorial</a> <a href="#">Drug Interactions</a> I <a href="#">E&amp;M Coding Recommendations</a> <a href="#">Infusion Flowsheet</a> <a href="#">Insulin Infusion</a>																												
<a href="#">Preventing Hypertension</a> I <a href="#">Smoking Cessation</a> I <a href="#">Care Coordination Referral</a> <a href="#">PC-MH Coordination Review</a> <b>Needs Attention!!</b> <a href="#">HEDIS</a> <a href="#">NQF</a> <a href="#">PQRS</a> <a href="#">ACO</a> <a href="#">Elderly Medication Summary</a> <a href="#">STARS Program Measures</a>																																
<b>Exercise</b> <a href="#">Exercise</a> I <a href="#">CHF Exercise</a> I <a href="#">Diabetic Exercise</a> I	<b>Pending Referrals</b> I																															
Patient's Pharmacy: [ ] Phone: ( ) - [ ] Fax: ( ) - [ ] <a href="#">Rx Sheet - Active</a> <a href="#">Rx Sheet - New</a> <a href="#">Rx Sheet - Complete</a> <a href="#">Home Health</a>	<table border="1"> <thead> <tr> <th>Status</th> <th>Priority</th> <th>Referral</th> <th>Referring Provider</th> </tr> </thead> <tbody> <tr><td>Completed</td><td>Immediate</td><td>Mammogram</td><td>Anwar</td></tr> <tr><td>Completed</td><td>Routine</td><td></td><td>Abbas</td></tr> <tr><td>Completed</td><td>Stat</td><td>Arterial Blood Gas</td><td>Holly</td></tr> <tr><td>Completed</td><td>Routine</td><td>Abdullah, Nabeel</td><td>Holly</td></tr> <tr><td>Completed</td><td>Routine</td><td>Abdullah, Nabeel</td><td>Holly</td></tr> <tr><td>Completed</td><td>Routine</td><td>Sleep Studies</td><td>Abbas</td></tr> </tbody> </table>	Status	Priority	Referral	Referring Provider	Completed	Immediate	Mammogram	Anwar	Completed	Routine		Abbas	Completed	Stat	Arterial Blood Gas	Holly	Completed	Routine	Abdullah, Nabeel	Holly	Completed	Routine	Abdullah, Nabeel	Holly	Completed	Routine	Sleep Studies	Abbas			
Status	Priority	Referral	Referring Provider																													
Completed	Immediate	Mammogram	Anwar																													
Completed	Routine		Abbas																													
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Completed	Routine	Abdullah, Nabeel	Holly																													
Completed	Routine	Abdullah, Nabeel	Holly																													
Completed	Routine	Sleep Studies	Abbas																													
				<b>Chart Note</b> <a href="#">Return Info</a> <a href="#">Return Doc</a> <a href="#">Email</a> <a href="#">Telephone</a> <a href="#">Records Request</a> <a href="#">Transfer of Care Doc</a>																												

# 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**).

**Tutorial**

**Evaluation and Management**

Acute Dx

Chronic Dx

Abd Pain Rebound Tende  
Baker Cyst Syno Cyst Pc  
Cachexia  
Dacryocystiis Eye  
E Coli Infection  
Face Contusion (No Eye)  
Gambling Pathological  
H/CKD Benign CKD 1-4 C  
Ichthyosis Congenita  
Keloid Scar  
Labial Adhesions Genital  
Malabsorption Celiac Ricl  
Nail Cong Anomaly Integu  
OA, Generalized  
DM Type II W/O Comp Cc  
Hyperten Malign Essential  
Jealousy, Sibling

Clear Diagnosis Fields

E-mail

Recommendations

Submit

Sent Successfully

In order to see the SUBMIT button, you MUST answer the E-Prescribing code question below in red.

**New Patients**

99201 Brief  
99202 Problem Focused  
99203 Expanded Problem  
99204 Detailed Problem  
99205 Comprehensive Problem

**Established**

99211 Brief  
99212 Problem Focused  
99213 Expanded Problem  
99214 Detailed Problem  
99215 Comprehensive Problem  
Observation/Discharge Management

**Nursing Home**

99304 Initial Limited  
99305 Initial Extended  
99306 Initial Comprehensive  
99307 Subsequent Limited  
99308 Subsequent Extended  
99309 Subsequent Comprehensive  
99310 Subsequent High Complexity  
99315 NH Discharge  
99316 NH Discharge, 30+ mins  
99318 Nursing Facility Care, Annual

99324 Domicil, New Pt, Prob Focus  
99325 Domicil, New Pt, Expanded  
99326 Domicil, New Pt, Detailed  
99327 Domicil, New Pt, Mod Comp  
99328 Domicil, New Pt, High Comp  
99334 Domicil, Est Pt, Prob Focus  
99335 Domicil, Est Pt, Expanded  
99336 Domicil, Est Pt, Detailed  
99337 Domicil, Est Pt, Comprehensive

**New Patients**

Commercial Insurance only

99381 Preventive Visit, Infant  
99382 Preventive Visit, Age 1 to 4  
99383 Preventive Visit, Age 5 to 11  
99384 Preventive Visit, Age 12 to 17  
99385 Preventive Visit, Age 18 to 39  
99386 Preventive Visit, Age 40 to 64  
99387 Preventive Visit, Age 65+

**Established**

Commercial Insurance only

99391 Preventive Visit, Infant  
99392 Preventive Visit, Age 1 to 4  
99393 Preventive Visit, Age 5 to 11  
99394 Preventive Visit, Age 12 to 17  
99395 Preventive Visit, Age 18 to 39  
99396 Preventive Visit, Age 40 to 64  
99397 Preventive Visit, Age 65+

**Consultation**

Referring

99241 Brief  
99242 Problem Focused  
99243 Expanded Problem  
99244 Comprehensive Problem

**Suture Removal**

99024 Suture Removal/Packing Rem

**Medicare Preventive**

G0402 Medicare Beneficiary Exam  
G0438 PPS Initial Visit  
G0439 PPS Subsequent Visit

**E-Prescribing**

Was at least one prescription during the encounter presented and submitted electronically?

Yes No

**Care Transition**

99495 Transition of Care Management within 14 days (99214 or higher)  
99496 Transition of Care Management within 7 days (99215)

**Comments** (Insert special instructions here then click email button.)

# CARE TRANSITIONS MANAGEMENT CODES

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

**Tutorial**

**Evaluation and Management**

Acute Dx

Chronic Dx

Abd Pain Rebound Tende

Baker Cyst Syno Cyst Pc

Cachexia

Dacryocystiis Eye

E Coli Infection

Face Contusion (No Eye)

Gambling Pathological

H/CKD Benign CKD 1-4 C

Ichthyosis Congenita

Keloid Scar

Labial Adhesions Genital

Malabsorption Celiac Ricl

Nail Cong Anomaly Integu

OA, Generalized

DM Type II W/O Comp Cc

Hyperten Malig Essential

Jealousy, Sibling

Hypertension

Clear Diagnosis Fields

E-mail

Recommendations

In order to see the SUBMIT button, you MUST answer the E-Prescribing code question below in red.

**New Patients**

99201 Brief

99202 Problem Focused

99203 Expanded Problem

99204 Detailed Problem

99205 Comprehensive Problem

**Established**

99211 Brief

99212 Problem Focused

99213 Expanded Problem

99214 Detailed Problem

99215 Comprehensive Problem

Observation/Discharge Management

**Nursing Home**

99304 Initial Limited

99305 Initial Extended

99306 Initial Comprehensive

99307 Subsequent Limited

99308 Subsequent Extended

99309 Subsequent Comprehensive

99310 Subsequent High Complexity

99315 NH Discharge

99316 NH Discharge, 30+ mins

99318 Nursing Facility Care, Annual

99324 Domicil, New Pt, Prob Focus

99325 Domicil, New Pt, Expanded

99326 Domicil, New Pt, Detailed

99327 Domicil, New Pt, Mod Comp

99328 Domicil, New Pt, High Comp

99334 Domicil, Est Pt, Prob Focus

99335 Domicil, Est Pt, Expanded

99336 Domicil, Est Pt, Detailed

99337 Domicil, Est Pt, Comprehensive

**New Patients**

*Commercial Insurance only*

99381 Preventive Visit, Infant

99382 Preventive Visit, Age 1 to 4

99383 Preventive Visit, Age 5 to 11

99384 Preventive Visit, Age 12 to 17

99385 Preventive Visit, Age 18 to 39

99386 Preventive Visit, Age 40 to 64

99387 Preventive Visit, Age 65+

**Established**

*Commercial Insurance only*

99391 Preventive Visit, Infant

99392 Preventive Visit, Age 1 to 4

99393 Preventive Visit, Age 5 to 11

99394 Preventive Visit, Age 12 to 17

99395 Preventive Visit, Age 18 to 39

99396 Preventive Visit, Age 40 to 64

99397 Preventive Visit, Age 65+

**Consultation**

Referring

99241 Brief

99242 Problem Focused

99243 Expanded Problem

99244 Comprehensive Problem

**Suture Removal**

99024 Suture Removal/Packing Rem

**Medicare Preventive** Eligibility

G0402 Initial Preventive Physical Exam

G0438 Annual Wellness Visit, Initial

G0439 Annual Wellness Visit, Subsequent

**Medicare Behavioral Therapy**

G0446 Intensive Therapy - Cardiovascular Disease

G0447 Intensive Therapy - Obesity

**E-Prescribing**

Was at least one prescription during the encounter generated and submitted electronically?

Yes

No

**Care Transition** Eligibility

99495 Transition of Care Management Within 14 days (99214 or higher)

99496 Transition of Care Management Within 7 days (99215)

**Comments** (Insert special instructions here then click email button.)



# CARE TRANSITIONS MANAGEMENT CODES

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

**Transitional Care Management**

Select Level Of Medical Decision Making For This Office Visit

Straight Forward [?](#)

Low Complexity [?](#)

Moderate Complexity [?](#)

High Complexity [?](#)

Date Of Most Recent Hospital Discharge

Days Since Most Recent Hospital Discharge

Date Of Most Recent Hospital Follow-Up Call

Days After Discharge Follow-Up Call Completed

*You may use the 99495 Transition Care Management code for this office visit. Click OK to close this template and the 99495 code will be selected for you on the next screen.*

*Don't forget to click Submit on the next screen.*

# 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.jameshollymd.com](http://www.jameshollymd.com) at the following link:  
  
<http://www.jameshollymd.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

[Tutorial](#)

## Evaluation and Management

Clear Diagnosis Fields      E-mail      **Submit**

In order to see the **SUMBIT** button, you **MUST** answer the E-Prescribing code question below in red.

Acute Dx	New Patients	New Patients Commercial Insurance only		
<input type="checkbox"/>	<input type="checkbox"/> 99201 Brief	<input type="checkbox"/> 99381 Preventive Visit, Infant		
<input type="checkbox"/>	<input type="checkbox"/> 99202 Problem Focused	<input type="checkbox"/> 99382 Preventive Visit, Age 1 to 4		
<input type="checkbox"/>	<input type="checkbox"/> 99203 Expanded Problem	<input type="checkbox"/> 99383 Preventive Visit, Age 5 to 11		
<input type="checkbox"/>	<input type="checkbox"/> 99204 Detailed Problem	<input type="checkbox"/> 99384 Preventive Visit, Age 12 to 17		
<input type="checkbox"/>	<input type="checkbox"/> 99205 Comprehensive Problem	<input type="checkbox"/> 99385 Preventive Visit, Age 18 to 39		
<input type="checkbox"/>		<input type="checkbox"/> 99386 Preventive Visit, Age 40 to 64		
<input type="checkbox"/>		<input type="checkbox"/> 99387 Preventive Visit, Age 65+		
Chronic Dx	Established	Established Commercial Insurance only		
<input type="checkbox"/> Abd Pain Rebound Tende	<input type="checkbox"/> 99211 Brief	<input type="checkbox"/> 99391 Preventive Visit, Infant		
<input type="checkbox"/> Baker Cyst Syno Cyst Pc	<input type="checkbox"/> 99212 Problem Focused	<input type="checkbox"/> 99392 Preventive Visit, Age 1 to 4		
<input type="checkbox"/> Cachexia	<input type="checkbox"/> 99213 Expanded Problem	<input type="checkbox"/> 99393 Preventive Visit, Age 5 to 11		
<input type="checkbox"/> Dacryocystiis Eye	<input type="checkbox"/> 99214 Detailed Problem	<input type="checkbox"/> 99394 Preventive Visit, Age 12 to 17		
<input type="checkbox"/> E Coli Infection	<input type="checkbox"/> 99215 Comprehensive Problem	<input type="checkbox"/> 99395 Preventive Visit, Age 18 to 39		
<input type="checkbox"/> Face Contusion (No Eye)	Observation/Discharge Management	<input type="checkbox"/> 99396 Preventive Visit, Age 40 to 64		
<input type="checkbox"/> Gambling Pathological		<input type="checkbox"/> 99397 Preventive Visit, Age 65+		
<input type="checkbox"/> H/CKD Benign CKD 1-4 C	<th>Nursing Home</th>	Nursing Home	<th>Consultation</th>	Consultation
<input type="checkbox"/> Ichthyosis Congenita	<input type="checkbox"/> 99304 Initial Limited	Referring <input type="text"/>		
<input type="checkbox"/> Keloid Scar	<input type="checkbox"/> 99305 Initial Extended	<input type="checkbox"/> 99241 Brief		
<input type="checkbox"/> Labial Adhesions Genital	<input type="checkbox"/> 99306 Initial Comprehensive	<input type="checkbox"/> 99242 Problem Focused		
<input type="checkbox"/> Malabsorption Celiac Ricl	<input type="checkbox"/> 99307 Subsequent Limited	<input type="checkbox"/> 99243 Expanded Problem		
<input type="checkbox"/> Nail Cong Anomaly Integt	<input type="checkbox"/> 99308 Subsequent Extended	<input type="checkbox"/> 99244 Comprehensive Problem		
<input type="checkbox"/> OA, Generalized	<input type="checkbox"/> 99309 Subsequent Comprehensive			
<input type="checkbox"/> DM Type II W/O Comp Cc	<input type="checkbox"/> 99310 Subsequent High Complexity	<th>Suture Removal</th>	Suture Removal	
<input type="checkbox"/> Hyperten Malig Essential	<input type="checkbox"/> 99315 NH Discharge	<input type="checkbox"/> 99024 Suture Removal/Packing Rem		
<input type="checkbox"/> Jealousy, Sibling	<input type="checkbox"/> 99316 NH Discharge, 30+ mins	<th>Medicare Preventive</th>	Medicare Preventive	
<input type="checkbox"/>	<input type="checkbox"/> 99318 Nursing Facility Care, Annual	<input type="checkbox"/> G0402 Medicare Beneficiary Exam		
<input type="checkbox"/>	<input type="checkbox"/> 99324 Domicil, New Pt, Prob Focus	<input type="checkbox"/> G0438 PPS Initial Visit		
<input type="checkbox"/>	<input type="checkbox"/> 99325 Domicil, New Pt, Expanded	<input type="checkbox"/> G0439 PPS Subsequent Visit		
<input type="checkbox"/>	<input type="checkbox"/> 99326 Domicil, New Pt, Detailed			
<input type="checkbox"/>	<input type="checkbox"/> 99327 Domicil, New Pt, Mod Comp	<th>E-Prescribing</th>	E-Prescribing	
<input type="checkbox"/>	<input type="checkbox"/> 99328 Domicil, New Pt, High Comp	Was at least one prescription <input checked="" type="radio"/> Yes		
<input type="checkbox"/>	<input type="checkbox"/> 99334 Domicil, Est Pt, Prob Focus	and submitted electronically? <input type="radio"/> No		
<input type="checkbox"/>	<input type="checkbox"/> 99335 Domicil, Est Pt, Expanded			
<input type="checkbox"/>	<input type="checkbox"/> 99336 Domicil, Est Pt, Detailed			
<input type="checkbox"/>	<input type="checkbox"/> 99337 Domicil, Est Pt, Comprehensive			
	<b>Care Transition Eligibility</b>			
	<input checked="" type="checkbox"/> 99495 Transition of Care Management within 14 days (99214 or higher)			
	<input type="checkbox"/> 99496 Transition of Care Management within 7 days (99215)			
	<b>Comments</b> (Insert special instructions here then click email button.)			

# QUESTIONS

Please feel free to ask any questions you may have.

You are welcome to contact Dr. Holly at [jholly@jameslhollymd.co](mailto:jholly@jameslhollymd.com)

[m](mailto: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.ihl.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.

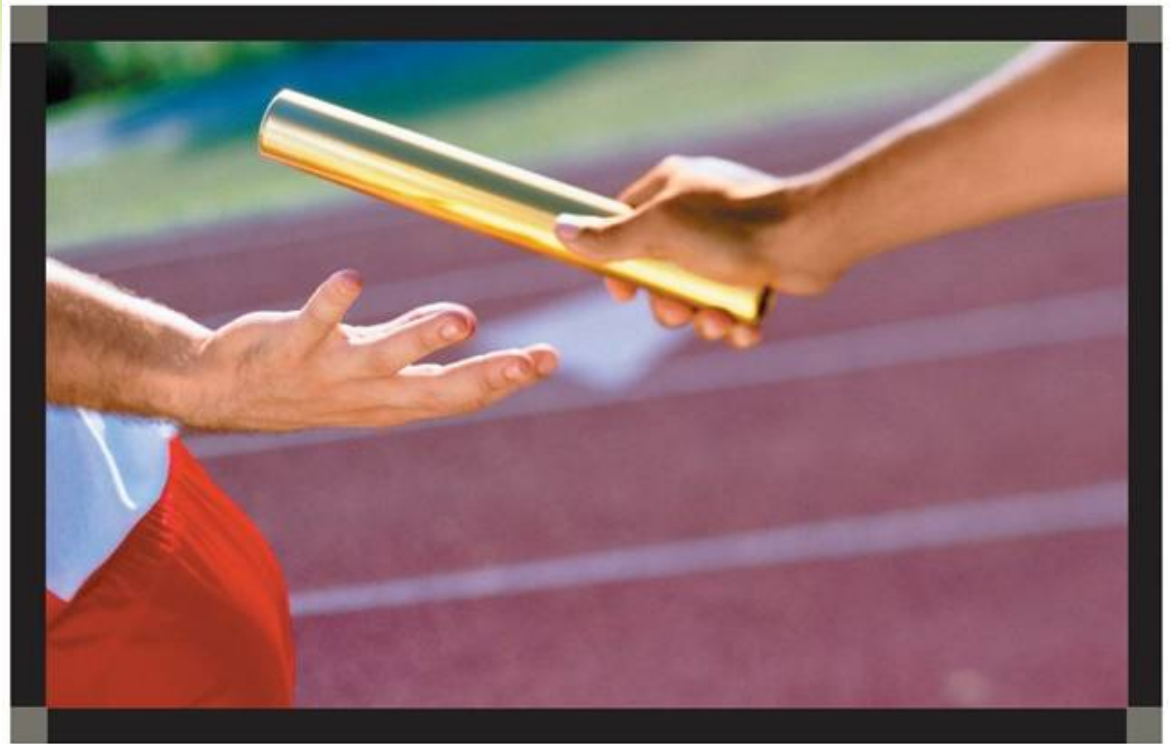
# SETMA'S MODEL OF CARE

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](http://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