Georgia Department of Community Health

Transition of Care

Presentation to: The Medical Care Advisory Committee

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Performance, Quality and Outcomes

Division of Medical Assistance Plans

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Georgia Department of Community Health

Mission

The mission of the Department of Community Health is to provide access to affordable, quality health care to Georgians through effective planning, purchasing, and oversight.

We are dedicated to A Healthy Georgia.

Georgia Department of Community Health

Overview

- The Transition Record Defined
- Transmitting the Transition Record
- The CMS Adult Core Set Transition of Care Metric
- DCH's Performance with this Metric
- Collaboration with GHA and their CCC
- Next Steps - Performance Improvement

The Transition Record

- In 2012, CMS defined the Transition Record as:
  - A core, standardized set of data elements related to enrollee's diagnosis, treatment, and care plan that is discussed with and provided to the enrollee in printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to the enrollee.
  - The Transition Record is NOT the same as the Discharge Instructions

The Transition Record Transmitted

- CMS defined transmitted as:
  - The transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR)

The Transmitted Information

- Per CMS, the Transition Record must contain:
  - The reason for the inpatient admission
  - Major procedures and tests, including summary of results
  - Current medication list and studies pending at discharge along with patient instructions
  - Advance directives or surrogate decision maker documented or documented reason for not providing advance care plan
  - 24/7 contact information including physician for emergencies related to the inpatient stay; plan for follow up care, PCP designated for follow up care
  - Date and time of discharge and information about the transmission of the transition record.

The Transition of Care Metric

- 2012 CMS defined this Adult Core Set Measure for states to report:
  - Percentage of discharges from an inpatient facility (hospital inpatient or observation, skilled nursing facility, or nursing facility) to home or any other site of care for which a transition record was transmitted to the facility or primary physician or other health care professional designated for follow up care within 24 hours of discharge, among Medicaid enrollees age 18 and older.

The Transition of Care Metric

Georgia Medicaid Performance Measure Report For CY2012 through CY2014											
	2012 FFS	2013 FFS	2014 FFS	2012 GA Families	2013 GA Families	2014 GA Families	2012 ALL	2013 ALL	2014 ALL	2013 FCAAJJ[6]	2014 FCAAJJ[6]
Care Transition - Transition Record Transmitted to Health Care Professional	0.00%	0.73%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

This is a hybrid metric requiring medical record reviews. The abstractors were not able to find all required components of the transition record in the members' charts.

The Transition of Care Metric - recap

- Meant to track transmission of relevant information sent from the hospital to the member's PCP or other care site to assist with follow up care
  - Transition information to contain 24/7 contact information including physician for emergencies; plan for follow up care; designated PCP
  - Evidence that the information was transmitted to the receiving entity
- DCH's performance = 0%

The Transition of Care and Hospital Re-admissions

- Consequence of Transition information not transmitted
  - Re-admission metric looks at number of acute inpatient stays during measurement year that were followed by unplanned acute re-admission for any diagnosis within 30 days – excludes deaths, pregnancy-related stay, planned re-admission (chemo, organ transplant, etc.)
  - The Medicaid 2013 30 day All Cause Re-admission rate was 10.18%
  - The CY 2014 30 day All Cause Re-admission rate was 14.43%

Transition of Care and Hospital Re-admissions

- DCH is member of the Georgia Hospital Association's Care Coordination Council.
- Care Coordination Council
  - Council comprised of GHA, hospital, nursing home, home health, Medicaid managed care, and DCH representatives
  - Goal to reduce all cause, all payor hospital readmission rate to 9% by December 2015

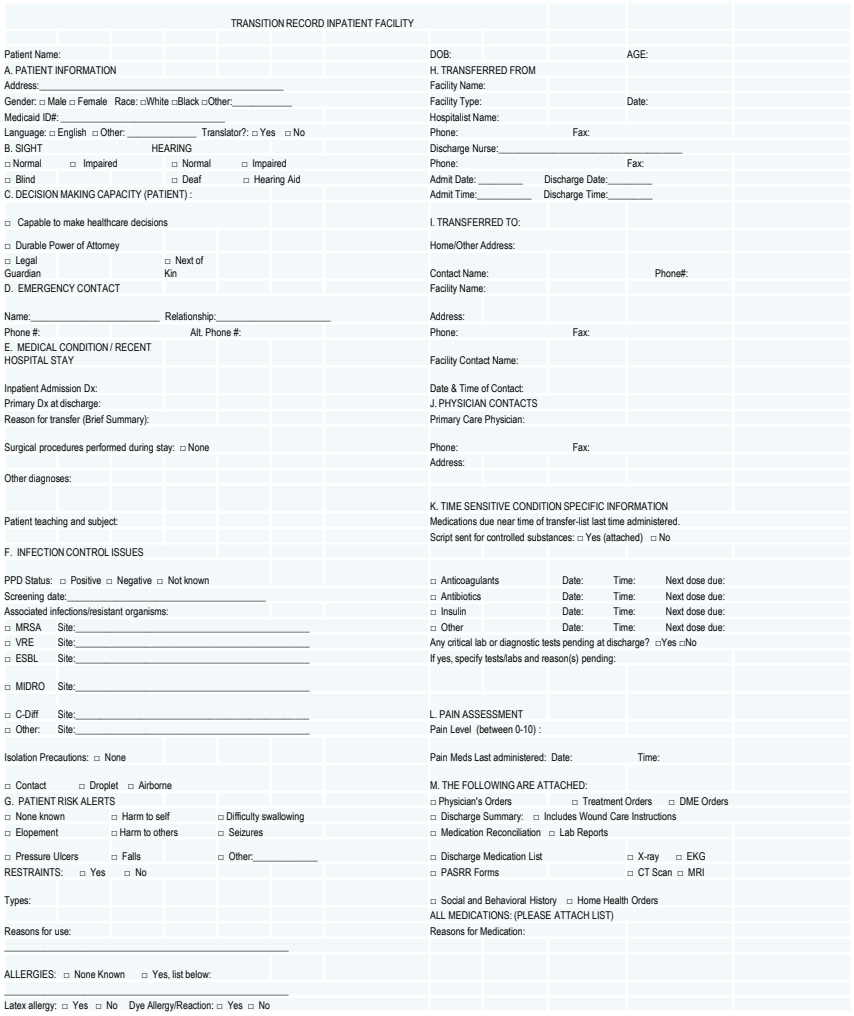
Partnership to Improve the Transition Process

- DCH stratified CY 2014 re-admission rates:
  - FFS = 14.71% or 7977/54237
    - (18 – 44 year olds (3448/14885) = 23.16%)
  - GF = 12.28% or 571/4648
    - (18 - 44 year olds (458/3732) = 12.27%)
- During recent GHA CCC meeting, hospital representatives noted increases in re-admissions specifically for respiratory conditions and mentioned FFS Medicaid members
  - Members not sure about discharge instructions and not able to obtain timely follow up appointments after inpatient stay.

Partnership to Improve the Transition Process

- DCH created a Transition of Care Record with all required components.
  - Submitted Record to CMS for review – they submitted Record to the AMA for review – new form now contains all required components.
  - Record to be populated by hospitals' EHRs
  - GHA piloting new Record with 3 hospital systems
  - DCH PQO staff partnering with the DCH MITA team to generate electronic transition record to be transmitted from hospitals to DCH and the CMOs after being sent to receiving provider.

Transition of Care Record



TRANSITION RECORD INPATIENT FACILITY

Patient Name:
A. PATIENT INFORMATION
Address:_____
Gender: □ Male □ Female Race: □White □Black □Other:_____
Medicaid ID#: _____
Language: □ English □ Other: _____ Translator?: □ Yes □ No
B. SIGHT HEARING
□ Normal □ Impaired □ Normal □ Impaired
□ Blind □ Deaf □ Hearing Aid
C. DECISION MAKING CAPACITY (PATIENT) :

□ Capable to make healthcare decisions

□ Durable Power of Attorney
□ Legal Guardian □ Next of Kin
D. EMERGENCY CONTACT

Name:_____ Relationship:_____
Phone #: Alt. Phone #:
E. MEDICAL CONDITION / RECENT HOSPITAL STAY

Inpatient Admission Dx:
Primary Dx at discharge:
Reason for transfer (Brief Summary):

Surgical procedures performed during stay: □ None

Other diagnoses:

Patient teaching and subject:

F. INFECTION CONTROL ISSUES

PPD Status: □ Positive □ Negative □ Not known
Screening date:_____
Associated infections/resistant organisms:
□ MRSA Site:_____
□ VRE Site:_____
□ ESBL Site:_____

□ MIDRO Site:_____

□ C-Diff Site:_____
□ Other: Site:_____

Isolation Precautions: □ None

□ Contact □ Droplet □ Airborne
G. PATIENT RISK ALERTS
□ None known □ Harm to self □ Difficulty swallowing
□ Elopement □ Harm to others □ Seizures

□ Pressure Ulcers □ Falls □ Other:_____
RESTRAINTS: □ Yes □ No

Types:

Reasons for use:

_____

ALLERGIES: □ None Known □ Yes, list below:

_____

Latex allergy: □ Yes □ No Dye Allergy/Reaction: □ Yes □ No

DOB: AGE:
H. TRANSFERRED FROM
Facility Name:
Facility Type: Date:
Hospitalist Name:
Phone: Fax:
Discharge Nurse:_____
Phone: Fax:
Admit Date: _____ Discharge Date:_____
Admit Time:_____ Discharge Time:_____
I. TRANSFERRED TO:

Home/Other Address:

Contact Name: Phone#:
Facility Name:

Address:
Phone: Fax:

Facility Contact Name:

Date & Time of Contact:
J. PHYSICIAN CONTACTS
Primary Care Physician:

Phone: Fax:
Address:

K. TIME SENSITIVE CONDITION SPECIFIC INFORMATION
Medications due near time of transfer-list last time administered.
Script sent for controlled substances: □ Yes (attached) □ No

□ Anticoagulants Date: Time: Next dose due:
□ Antibiotics Date: Time: Next dose due:
□ Insulin Date: Time: Next dose due:
□ Other Date: Time: Next dose due:
Any critical lab or diagnostic tests pending at discharge? □Yes □No
If yes, specify tests/labs and reason(s) pending:

L. PAIN ASSESSMENT
Pain Level (between 0-10) :

Pain Meds Last administered: Date: Time:

M. THE FOLLOWING ARE ATTACHED:
□ Physician's Orders □ Treatment Orders □ DME Orders
□ Discharge Summary: □ Includes Wound Care Instructions
□ Medication Reconciliation □ Lab Reports

□ Discharge Medication List □ X-ray □ EKG
□ PASRR Forms □ CT Scan □ MRI

□ Social and Behavioral History □ Home Health Orders
ALL MEDICATIONS: (PLEASE ATTACH LIST)
Reasons for Medication:

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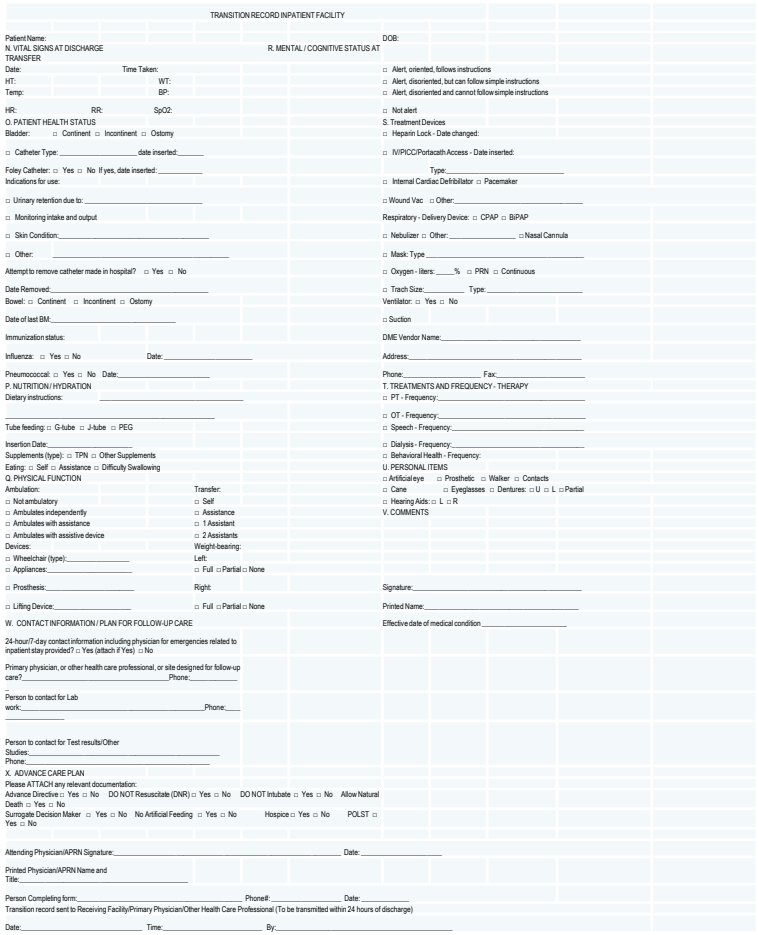
Transition of Care Record



TRANSITION RECORD INPATIENT FACILITY

Patient Name: DOB:

N. VITAL SIGNS AT DISCHARGE

Date: Time Taken:

HT: WT:

Temp: BP:

HR: RR: SpO2:

O. PATIENT HEALTH STATUS

Bladder: □ Continent □ Incontinent □ Ostomy

□ Catheter Type: _____ date inserted:_____

Foley Catheter: □ Yes □ No If yes, date inserted:_____

Indications for use:

□ Urinary retention due to: _____

□ Monitoring intake and output

□ Skin Condition:_____

□ Other: _____

Attempt to remove catheter made in hospital? □ Yes □ No

Date Removed:_____

Bowel: □ Continent □ Incontinent □ Ostomy

Date of last BM:_____

Immunization status:

Influenza: □ Yes □ No Date:_____

Pneumococcal: □ Yes □ No Date:_____

P. NUTRITION / HYDRATION

Dietary instructions: _____

_____

Tube feeding: □ G-tube □ J-tube □ PEG

Insertion Date:_____

Supplements (type): □ TPN □ Other Supplements

Eating: □ Self □ Assistance □ Difficulty Swallowing

Q. PHYSICAL FUNCTION

Ambulation:

□ Not ambulatory

□ Ambulates independently

□ Ambulates with assistance

□ Ambulates with assistive device

Devices:

□ Wheelchair (type):_____

□ Appliances:_____

□ Prosthesis:_____

□ Lifting Device:_____

Transfer:

□ Self

□ Assistance

□ 1 Assistant

□ 2 Assistants

Weight-bearing:

Left:

□ Full □ Partial □ None

Right:

□ Full □ Partial □ None

W. CONTACT INFORMATION / PLAN FOR FOLLOW-UP CARE

24-hour/7-day contact information including physician for emergencies related to inpatient stay provided? □ Yes (attach if Yes) □ No

Primary physician, or other health care professional, or site designed for follow-up care?_____Phone:_____

Person to contact for Lab work:_____Phone:_____

Person to contact for Test results/Other Studies:_____

Phone:_____

X. ADVANCE CARE PLAN

Please ATTACH any relevant documentation:

Advance Directive □ Yes □ No DO NOT Resuscitate (DNR) □ Yes □ No DO NOT Intubate □ Yes □ No Allow Natural Death □ Yes □ No

Surrogate Decision Maker □ Yes □ No No Artificial Feeding □ Yes □ No Hospice □ Yes □ No POLST □ Yes □ No

Attending Physician/APRN Signature:_____ Date:_____

Printed Physician/APRN Name and Title:_____

Person Completing form:_____ Phone#:_____ Date:_____

Transition record sent to Receiving Facility/Primary Physician/Other Health Care Professional (To be transmitted within 24 hours of discharge)

Date:_____ Time:_____ By:_____

R. MENTAL / COGNITIVE STATUS AT TRANSFER

□ Alert, oriented, follows instructions

□ Alert, disoriented, but can follow simple instructions

□ Alert, disoriented and cannot follow simple instructions

□ Not alert

S. Treatment Devices

□ Heparin Lock - Date changed:

□ IV/PICC/Portacath Access - Date inserted:

Type:_____

□ Internal Cardiac Defibrillator □ Pacemaker

□ Wound Vac □ Other:_____

Respiratory - Delivery Device: □ CPAP □ BiPAP

□ Nebulizer □ Other:_____ □ Nasal Cannula

□ Mask: Type _____

□ Oxygen - liters:_____% □ PRN □ Continuous

□ Trach Size:_____ Type:_____

Ventilator: □ Yes □ No

□ Suction

DME Vendor Name:_____

Address:_____

Phone:_____ Fax:_____

T. TREATMENTS AND FREQUENCY - THERAPY

□ PT - Frequency:_____

□ OT - Frequency:_____

□ Speech - Frequency:_____

□ Dialysis - Frequency:_____

□ Behavioral Health - Frequency:

U. PERSONAL ITEMS

□ Artificial eye □ Prosthetic □ Walker □ Contacts

□ Cane □ Eyeglasses □ Dentures: □ U □ L □ Partial

□ Hearing Aids: □ L □ R

V. COMMENTS

Signature:_____

Printed Name:_____

Effective date of medical condition _____

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Next Steps – Performance Improvement

- PQO Team conducting analysis of claims for FFS population with high re-admission rates to determine patterns – similar diagnoses, hospitals, providers, etc.
  - Many FFS members may not have PCP to follow up with after hospital admission
- Design project to address findings from analysis
- Would like input from MCAC to assist with improvement project design

Questions