

TRANSITIONS OF CARE & COMPACTS

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CTC-RI Practice Transformation/
Reporting Meeting

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WHAT ARE TRANSITIONS OF CARE

CMS Definition: movement of a patient from one setting of care to another, such as:

- ED to IP
- ED to home
- IP to home

PEDIATRIC TRANSITIONS OF CARE

Do they differ from adult TOC?

TRANSITION FROM PEDIATRIC TO ADOLESCENT CARE

.

She tells parents, "I really need to be your child's physician, and it's really important that I have a rapport with him or her. I need the child to trust me, and I need you to trust me," she said at a conference sponsored by the North Pacific Pediatric Society.

"I need you to trust that I'm going to tell you if there's a serious medical problem that is uncovered when your child talks with me.

Dr. Cora C. Breuner

Source: <https://www.mdedge.com/pediatrics/article/54350/pediatrics/prepare-parents-leave-exam-room>

TRANSITION OF CARE FROM ADOLESCENT CARE TO ADULT

Excerpt from Coastal Waterman Pediatrics letter:

Once your teen turns 18, some important changes occur in the way you can interact with our office. Your teen becomes a legal adult at 18 and therefore has FULL confidentiality rights. That means that we legally cannot release ANY information to ANYONE (other than the patient) without specific permission. *

Can we answer any of these typical questions?

The date of next appointment? Nope.

The results of the recent lab work? Nope.

Our thoughts on that funny looking mole? Nope.

You can give us information, but we cannot give you any unless we have specific permission to do so. Please don't be frustrated with our staff when they can't answer your questions.

WHY ARE WE CONCERNED ABOUT TOC

- 10,000 pediatric hospital discharges/day
- duplicative care
- discrepancies in medication information
- incomplete documentation of important health information
- understanding and executing discharge plans
- increased likelihood of hospital readmission

Source: Berry, J. G., Blaine, K., Rogers, J., McBride, S., Schor, E., Birmingham, J., ... Feudtner, C. (2014). A framework of pediatric hospital discharge care informed by legislation, research, and practice. *JAMA pediatrics*, 168(10), 955–966. doi:10.1001/jamapediatrics.2014.891

Process: Care Transitions to/from Hospital and ED

Purpose: To establish a process for coordinating patient care during and after transitions to acute care settings

A. Hospital Admissions

<Define & describe admission process used and staff responsible (multiple processes may apply)>

CC 14

1. Hospital admission process –
<direct, hospitalist, scheduled, unplanned, through ED, etc.>

CC 15

2. Standard documentation provided to hospital for admission <summaries, referrals, notes, reason, special requests, admit orders, shared EHR, etc.>
3. Method of providing documentation to hospital <direct electronic interface, through HIE, fax, patient carries materials, phone calls to hospitalist, shared EHR, etc.>
4. Method of noting admissions in the practice EHR or chart <ability to obtain list of admitted patients from EHR or hospitals (see below)>

B. Hospital Stay

<Define & describe communication process used, staff responsible (multiple processes may apply)>

CC 14

1. Agreements with hospitals to obtain daily Census lists <frequency & method of receipt>
2. Information received <calls with attending and/or consulting specialists, status updates, consult notes, hospital rounds, in-hospital consultations, etc.>
3. Information sent <notes, test results, meds, allergies, all consultation models mentioned above>
4. Information exchange <electronic, fax, HIE, phone, in-person consults, patient/family, etc.>
5. After-hours information exchange <on-call provider, 24/7 access to EHR, phone calls, etc.>

CC 17

C. Hospital Discharge

<Define & describe discharge process used and staff responsible (multiple processes may apply)>

CC 14

CC 19

1. Notification of discharge from hospital
 - a. Discharge list from hospital (or plans) <push by hospital/plans, pull by practice, combination, etc.>
 - b. Content <discharge summary, interim letter, other>
 - c. Method <direct electronic push, HIE push, faxed push, pull by the practice, access to hospital system, shared EHR, payer portals, sent with patient, other>
 - d. Added to patient record <scanned in, electronically attached, etc.>
 - e. Time frame <received within XX days from discharge>
2. Actions taken <patient call, call with hospitalist, contact consulting specialist(s), contact with discharge/case manager, scheduled follow up, house call, other>
3. Time frame for follow up <XX days within 30 days period after discharge>

CC 16

D. ED Visits

<Define & describe communication process used and staff responsible (multiple processes may apply)>

CC 14

1. Agreements with ED to <contact PCP, provide daily lists>
2. Information received <calls with ER physician and/or consulting specialists, status updates, ED summary notes, etc.>
3. Information sent <notes, test results, meds, allergies, phone consultation>
4. Information exchange <electronic, fax, HIE, phone, in-person consults, etc.>

CC 18

E. ED Discharge

<Define & describe discharge process used and staff responsible (multiple processes may apply)>

CC 14

CC 19

1. Notification of discharge from ED
 - a. Discharge list from ED (or plans) <push by hospital/plans, pull by practice, combination, etc.>
 - b. Content <discharge summary, interim letter, other>
 - c. Method <direct electronic push, HIE push, faxed push, pull by the practice, access to hospital system, shared EHR, payer portals, sent with patient, other>
 - d. Added to patient record <scanned in, electronically attached, etc.>
 - e. Time frame <received within XX days from visit>
2. Actions taken <patient call, call with ED, contact consulting specialist(s), contact with discharge/case manager, scheduled follow up, house call, other>
3. Time frame for follow up <XX days after discharge>

CC 16

NCQA PCMH 2017 REQUIREMENTS


Competency

CC 14	CC15	CC16	CC17	CC18	CC19

Core vs. credit

Credit	CC17	CC18	CC19		
Core	CC14	CC15	CC16		

CC 14 (Core) Identifying Unplanned Hospital and ED Visits: Systematically identifies patients with unplanned hospital admissions and emergency department visits.

GUIDANCE	EVIDENCE
<p>The practice has a process for monitoring unplanned admissions and ED visits, including their frequency.</p> <p>The practice works with local hospitals, EDs and health plans to identify patients with recent unplanned visits, and demonstrates how it systematically receives notifications from facilities with which the practice has established mechanisms for exchange.</p>	<ul style="list-style-type: none">• Documented process <p>AND</p> <ul style="list-style-type: none">• Evidence of implementation 

CC 15 (Core) Sharing Clinical Information: Shares clinical information with admitting hospitals and emergency departments.

GUIDANCE

The practice demonstrates timely sharing of information with admitting hospitals and EDs. The practice provides three examples as evidence of implementation.

Shared information supports continuity in patient care across settings.

EVIDENCE

- **Documented process**
- AND**
- **Evidence of implementation**



CC 16 (Core) Post-Hospital/ED visit Follow-Up: Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit.

GUIDANCE

The practice contacts patients to evaluate their status after discharge from an ED or hospital, and to make a follow-up appointment, if appropriate. The practice's policies define the appropriate contact period and systematically documents follow-up.


Contact includes offering care to prevent worsening of a condition, clarify discharge instructions and encourage follow-up care, which may include, but is not limited to, physician counseling, referrals to community resources and disease or case management or self-management support programs.

EVIDENCE

- **Documented process**
- AND**
- **Evidence of implementation**



CC 17 (1 Credit) Acute Care After Hours Coordination: Systematic ability to coordinate with acute care settings after office hours through access to current patient information.

GUIDANCE	EVIDENCE
<p>The practice has a process to coordinate with acute care facilities when a patient is seen after the office is closed.</p> <p>Sharing patient information allows the facility to coordinate patient care based on current health needs and engage with practice staff.</p>	<ul style="list-style-type: none">• Documented processAND• Evidence of implementation <div data-bbox="1281 946 1416 1053"></div> <p><i>Documented process only</i></p>

CC 18 (1 Credit) Information Exchange during Hospitalization: Exchanges patient information with the hospital during a patient's hospitalization.

GUIDANCE

The practice demonstrates that it can send and receive patient information during a patient's hospitalization.

Note: CC 15 assesses the practice's ability to share information, but the focus of CC 18 is two-way exchange of information.

EVIDENCE

- Documented process
- AND**
- Evidence of implementation





CC 19 (1 Credit) Patient Discharge Summaries: Implements a process to consistently obtain patient discharge summaries from the hospital and other facilities.

GUIDANCE

The practice has a process for obtaining patient discharge summaries for patients following discharge from a hospital or other care facility. The practice shows that it obtains discharge summaries directly or demonstrates participation in a local admission, discharge, transfer (ADT) system.

Actively gathering information about patient admissions, discharges or transfers from the hospital and other care facilities improves care coordination, safe handoffs and reduces readmissions.

EVIDENCE

- **Documented process**
- AND**
- **Evidence of implementation**



BEHAVIORAL HEALTH OR GENERIC COMPACT WITH A SPECIALIST

Collaborative Care Management

Mutual Agreement between Quality Behavioral Health Management Services and Generic

- Define responsibilities between Generic and Quality Behavioral Health (QBH)
- Define scope of practice and identify care team



Expectations for specialty Psychiatric and Behavioral Health services provided by Quality Behavioral Health Management Services	
Generic	Psychiatric (Behavioral Health) services provided by Quality Behavioral Health Management Services
<ul style="list-style-type: none"> □ Provide adequate space for the evaluation and treatment of residents (patients) on site □ Informs patient of need, purpose, expectations, and goals of the Psychiatric (Behavioral Health), visit with Quality Behavioral Health Management Services □ Informs patient of their right to freely choose their behavioral health providers and explains benefit of this compact relationship □ Communicates reason for referral and sends relevant information to Quality Behavioral Health Management Services such as laboratory results, scans, etc. [or informs of documents in EHR] □ Schedules appointments with Quality Behavioral Health Management Services for patient or provides patients with the contact information and expected timeframe for the appointment with Quality Behavioral Health Management Services 	<ul style="list-style-type: none"> □ Have timely appointment availability within a reasonable timeframe to meet patient care needs □ The QBH care team will consist of a Board Certified Licensed Psychiatrist, a Nurse Practitioner (APRN) for medication management, a Licensed Social Worker, Licensed Mental Health Counselor or Psychologist to provide psychotherapy and a Neuro-Psychologist to provide psychological testing. □ QBH providers will use only evidence-based treatments □ Orders appropriate diagnostic testing and treatment for patient, including the ordering of RX and refills while the patient is under direct care of Quality Behavioral Health Management Services specialty Psychiatric and Behavioral Health care. □ Informs patient of diagnosis, prognosis, and

- Ensures QBH provider is informed of any changes in a patient's condition if changes are relevant to behavioral health care.
- Follows up with patients who did not follow through with appointments to assist in problem solving
- Resumes care of Patient when patient returns from behavioral health care and acts on care plan developed by QBH providers
- Utilizes urgent availability (2-7 business days) and "curbside consultation" access provided by QBH in an appropriate Manner that recognizes such access as a highly valued resource
- Agrees to work with QBH to ensure shared population receives all appropriate medical evaluation before or after consultation with QBH
- Agrees to engage in collaborative discussion with QBH leadership regarding future opportunities to employ outcome measures and actionable utilization data to improve health and healthcare and reduce healthcare costs for the shared population of patients

follow-up recommendations

- Provides appropriate educational materials and resources for patient/family
- Sends timely reports to PCP to include a care plan, follow up, recommendations, and results of psychiatric evaluations or therapeutic interventions
- Confers with PCP or establishes other protocol before referring to secondary or tertiary specialist, obtains prior authorizations, if required.
- Agrees to work with Generic to ensure shared population receives all appropriate medical evaluations, medication management and evidenced based psychotherapy.
- Recommends appropriate follow-up with PCP
- QBH Psychiatrist will provide consultation services with Generic nursing staff upon request and upon agreed on remuneration
- Agrees to engage in collaborative discussion with Generic leadership regarding future opportunities to employ outcome measures and actionable utilization data to improve health and healthcare and reduce healthcare costs for the shared population of patients
- Emergency Crisis Evaluation services

**Sample Primary Care Center/Urgent Care Center
Memorandum of Understanding**

A) Purpose

- To provide optimal health care for our patients.
- To provide a framework for highly effective collaboration between primary care and Concentra Urgent care providers.

B) Principles

- High quality and timely patient care is our central goal.
- When urgent care is required, effective communication between primary care and urgent care center is an essential component to providing optimal patient care.

C) Definitions

- Patient-Centered Medical Home –a community-based and culturally sensitive model of primary care that ensures every patient has a personal physician who guides a team of health professionals to provide the patient with accessible, coordinated, comprehensive and continuous health care across all stages of life.
- Medical Neighborhood – a system of care that integrates the PCMH with the medical specialists, and, as needed, urgent care providers and hospitals in the community through enhanced, bidirectional communication and collaboration on behalf of the patient.



Expectations for Primary Care and Urgent Care Center	
Primary Care	Urgent Care Center
<ul style="list-style-type: none">Supply results of recent studies that would facilitate the urgent care visitInforms patient of need, purpose, expectations, and goals of the urgent care visitCommunicates reason for referral to the urgent care center and sends relevant information to the urgent care center (laboratory results, scans, etc.) [or informs of documents in EHR]Follow up with patients who did not follow through with urgent care center to assist in problem solvingResumes care of patient when patient returns from urgent care center	<ul style="list-style-type: none">Is available to see referred patients within the hours of operation which includes (PM hours) and ____ (week end hours)Orders appropriate diagnostic testing and treatment for patient, including the ordering of RX, obtains prior authorization if requiredInforms patient of diagnosis, prognosis, and follow-up recommendationsProvides appropriate educational materials and resources for patient/familySends timely reports to PCP to include a care plan, follow up, recommendations, and results of diagnostic studies or therapeutic interventionsConfers with PCP or establishes other protocol before refers to secondary or tertiary specialist. obtains prior authorization, if required.



Primary Care Physician

Date

Urgent Care Provider

Date

COMPACTS AND COMANGEMENT

CC 12 (1 Credit) Co-Management Arrangements: Documents co-management arrangements in the patient's medical record.

GUIDANCE

When a particular specialist regularly treats a patient, the primary care clinician and the specialist enter into an agreement that enables safe and efficient co-management of the patient's care. Under the agreement, the primary care clinician and specialist share changes in the treatment plan and patient health status, in addition to entering information in the medical record within an agreed-on time frame.

The practice must provide three examples of such arrangements.

EVIDENCE

- **Evidence of implementation**

VALUABLE RESOURCE FOR COMPACTS: HIGH VALUE CARE COORDINATION (HVCC) FROM ACP

Check out their toolkit: <https://www.acponline.org/clinical-information/high-value-care/resources-for-clinicians/high-value-care-coordination-hvcc-toolkit>

Resources:

- Pertinent data sets (asthma, for example)
- Guide for relaying information to patients/families
- Care coordination agreements
- Checklists for providers



Blue Cross & Blue Shield of Rhode Island Advanced Primary Care Program Policies

Effective 7/01/2019

Review handout and discuss workflows