COOK COUNTY HEALTH & HOSPITALS SYSTEM CCHHS	AMBULATORY COMMUNITY HEALTH NETWORK	
Subject/Section: Patient Centered Medical Home	Page:	Policy #:
Title: Hospital to PCMH Transition of Care: New and Established Patient	Approval Date:	Posting Date:
Approval Party Kathi Braswell, Interim Outpatient COO Enrique Martinez MD- Outpatient CMO	Effective Date: Draft 4/7/13	

PURPOSE:

Hospital to PCMH Transition of Care (TOC) supports PCMH patients by minimizing gaps in needed healthcare services and/or delays in care by ensuring care coordination during the transition between hospital inpatient/ED settings and their primary care within the PCMH. The PCMH Care Management Model focuses on supporting patients during TOC to avoid preventable hospital admissions and reduce hospital readmissions. The TOC policy supports the CCHHS PCMH principles of team based care that is patient centered. Care coordination across sites of care minimizes delay and gaps in care when patients may be vulnerable to unexpected or poor outcomes.

AREAS AFFECTED:
All primary care sites/services will utilize best practices for Transition of Care.

CROSS REFERENCE: MHN Connect Policy

POLICY GUIDELINES:
These guidelines reflect the evolving model and work of the Patient-Centered Medical Home. As such, they are living documents that will be frequently updated. They also reflect that transitions of care are a high priority by the PCMH team for care management and coordination.

PCMH teams will facilitate safe, planned transitions in care for patients moving between inpatient (hospital) and outpatient (ED, observation) and PCMH care settings. They will evaluate TOC for opportunities to improve access at the appropriate level of service and provide transitional care coordination for safe transitions between service sites. Team members will use outreach and care coordination strategies to prevent gaps in care, errors in care, minimize readmissions and engage the patient in self-care and self-management.

Nationally accepted guidelines for care transitions will be used to guide these recommendations. These include three primary areas of focus for the PCMH team during care transitions;

- Timely Access to Primary Care and to the PCMH team
- Outreach and engaging patients early to decrease gaps in care and/or delays in care and to provide focused patient education and instruction. This instruction

includes self-management skills of recognizing signs and symptoms of worsening conditions and how to respond

- Medication review to include changes in medications and adherence assessment. This is intended to minimize errors and delays in care and to avoid readmissions.

PROCEDURE:

1. Timely Access to Primary Care and the PCMH team

a. Receive notification of patient hospitalization and/or ED visit.

The PCMH will be notified of empaneled patients' hospitalization and/or ED visits through several mechanisms:

- Alerts in MHN Connect portal
- Admission notices through Cerner to the PCP.
- Relationships with neighboring community hospitals.

b. Conduct outreach phone call within 72 hours of discharge. All PCMH patients seen in an ED or discharged from a hospital inpatient stay will be contacted within 72 hours of discharge. The decision of which team member will perform the outreach will be determined by information that is gained at the time of discharge notification. Patients with complex care needs (e.g. multiple chronic conditions or exacerbation of asthma, CHF or COPD) will be initially contacted by a licensed team member.

PCMH patients with apparent lower acuity visits may receive their initial outreach from a non-licensed team member who has received instruction in TOC outreach. Non licensed team members must include questions in the following 4 areas for all TOC outreach calls

1) Do you have any trouble understanding your instructions from the hospital or any trouble following those instructions? Do you have any concerns about the instructions?
2) Were any new medications prescribed to you in the ED or hospital?
3) Were any of your regular home medications changed or stopped in the hospital or ED?
4) Would you like to speak to a nurse?

*If patient answers "Yes" to the question/s, the unlicensed team member must perform a warm hand off a licensed **clinical** team member.

***Warm Hand Off**

If the unlicensed team member receives a positive response to any of the highlighted questions, she will ask the patient to speak with the RN (or other licensed staff member). She will obtain a phone number (in the event of disconnection) and transfer the call to the RN to evaluate the information and determine next steps. This may be an expedited appointment, social services referral or other action to support the patient and avoid gaps in care during the transition.

c. Schedule PCMH follow-up visit within 7 days of discharge per appointment criteria.

Appointment Criteria:

- PCP appointment within 7 days for all hospitalized patients.
- PCP Appointment within 7 days for all ED patients with exacerbation of CHF, COPD or asthma, **or** for any Illinois Health Connect (or County Care) patient. **Document these in** MHN Connect. IHC (and CountyCare) patients' transition-of-care visits must also be **documented in MHNconnect as completed**
- Care Manager phone call or nurse only visit may be appropriate for patients with ED visit for Ambulatory Sensitive Conditions* (see list at the end of this document)

d. Ensure documentation. Documentation must be completed in Cerner for all inreach and outreach contact of patients during TOC using the TOC note in Cerner. .

e. Communicate with team. Send message in the Message Center to PCP and Care Manager that note is available.

2. Medication Reconciliation and Adherence

Conduct medication reconciliation and adherence for all hospital and selected ED follow up patients at PCMH follow up visit prior to the patient seeing the PCP. (May be performed by RN at face-to-face visit or by phone if appropriate.)

Medication Reconciliation

Medication reconciliation will be supported on all TOC patients. RNs will complete the medication by history portion of the patient record (Cerner).

The Medication History note should review all prescribed medications, over-the-counter medications and health/nutritional supplements. Medications at discharge will be compared to the member's prior medication history, and discrepancies should be noted. Clinical judgment within the scope and experience of a licensed provider will be used to determine which medications will be continued after hospitalization.

Medication adherence will be conducted by a RN and **documented** in *Cerner as a correspondence entry titled: "Medication Adherence."*

3. Patient Engagement and Self-Care Education and Support

- New patients will receive information about PCMH, their assigned provider and medical home. (see script)
- All patients will receive information on accessing the clinic and their PCMH team. (see script)

- Patients with chronic conditions will receive focused instruction on recognizing signs and symptoms or worsening conditions with clear decision points and action plan on how to respond.
- Nursing staff will receive training in self-management and self-care support, focused goal setting and creating individualized plans of care with patients

IMPORTANT NOTE:
Concurrent development of Cerner documentation and decision support tools as CCHHS access needs will impact the TOC process of this policy. Be sure to use the most current policy to make sure that it reflects the documentation and process changes.

* Ambulatory Sensitive Conditions (ASC) Intervention
Patients hospitalized or seen in the ED with ASC would benefit from health literacy and focused education including recognizing worsening signs and symptoms, when to access the PCMH, how to access the PCMH and evaluation for additional needs or barriers to achieving best outcomes.

- Bacterial pneumonia
- Hypertension
- Dehydration
- Adult asthma
- Pediatric gastroenteritis
- Pediatric asthma
- Urinary tract infection
- Chronic obstructive pulmonary disease (COPD)
- Perforated appendix
- Diabetes short-term complication
- Low birth weight
- Diabetes long-term complication
- Angina without procedure
- Uncontrolled diabetes
- Congestive heart failure (CHF)
- Lower-extremity amputation among patients with diabetes