# Transition of Care Project

## Report for Harvard Pilgrim Health Care

**February 21, 2011**

<table>
<thead>
<tr>
<th>LCU Name</th>
<th>UMass Memorial Health Care</th>
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<tbody>
<tr>
<td>Project Title</td>
<td>Transitions of Care</td>
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(Content for this section is taken from the UMMHC Web site at [http://www.umassmemorial.org](http://www.umassmemorial.org) where more details may be found)

UMass Memorial Health Care is the largest health care system in Central and Western Massachusetts, and the clinical partner of the University of Massachusetts Medical School.

UMMHC system includes five hospitals, all fully accredited by the Joint Commission; UMass memorial Medical Center (Worcester, MA); Clinton Hospital (Clinton, MA); HealthAlliance Hospital (Leominster and Fitchburg, MA); Marlborough Hospital (Marlborough, MA); Wing Memorial Hospital (Palmer, MA).

The system includes home health and hospice programs, behavioral health programs and community-based practices. Approximately 1,700 physicians are members of the medical staff, active in patient care delivery. UMMHC employs 13,750 professionals including 3,100 registered nurses. The combined hospitals host 1,125 beds. In 2009 UMMHC treated 58,278 inpatients and more than 1.3 million outpatient visits. UMMHC delivered 5,400 babies and the Emergency Department handled 264,500 visits.

The Medical Center, UMass Memorial Medical Center, is accredited by the American College of Surgeons as the only designated Level one Trauma Center for adults and children in Central Massachusetts. The University Campus serves as home to the new Duddie Massad Emergency and Trauma Center and Life Flight, New England’s first hospital-based air ambulance. The Memorial Campus hosts the region’s only Level III Newborn Intensive Care Unit.

## Project Description

Our Transitions of Care Pilot is designed to improve patient-centered care by extending our previous Patient-Centered Medical home (PCMH) efforts to include care transitions from the inpatient setting back to the PCMH primary care practices. Our project focused on care coordination through improved Hospitalist – PCP two-way communication. Our hope was to examine existing communication silos and bridge the gap between inpatient care provision and ambulatory care provision in a meaningful and productive manner leading to improved transition of patient care.

To accomplish our project goals, a cross functional, multi-stakeholder Transitions of Care team was created in early January 2010 to focus on the goals and objectives of the project in accordance with our Harvard Pilgrim Healthcare Quality Grants Program 2010 Application. The pilot team consisted of representatives from the Hospitalist team, Nursing, Practice Improvement Facilitation, and Primary Care Practitioners. All professionals were deeply involved and completely committed to improving communication and continuity of care.

We held our project kickoff in June 2010. Through the development, documentation, and sharing of Hospitalist and Primary Care Practice work flows, processes, and procedures the project went live in mid-July 2010. The success of our first week and subsequent project work was in large part the result of joint planning, careful coordination, ongoing communication among participating project professionals, and cohesive implementation efforts.
A major success of our Pilot was the creation of and generation of a Daily Report. The Daily Report, generated by our designated Hospitalist Secretary, aggregates data for each participating primary care practice describing new, current, and discharged patients. Per patient status updates are provided, including expected date of discharge, anticipated discharge disposition, important information for the PCP to know such as when follow up appointments should be made, and comments or questions for the PCP. The Daily Report also allows the PCP to know which Hospitalist Team to contact should he/she have questions or want to share patient information with the in-hospital care providers. The Daily Report is manually generated by the Hospitalist Secretary and sent to a Global Email Exchange (GEA) set up by Information Technology in the participating PCP offices.

A highly regarded and much appreciated aspect of the Daily Report is the commentary from the Hospitalists communicated via the report to the PCPs on a per patient basis. This method has been shown in our Pilot to save time for both Hospitalists and PCPs. Instead of waiting on the telephone to contact a PCP, Hospitalists take time to deliver information to the Hospitalist Secretary via a single phone call. Daily Reports are generated each business day. They are not generated on weekends or holidays. Patients admitted on weekends or holidays are reported on the next business day.

The success of the Daily Report has led our team to actively investigate the potential use by our Hospitalist Physicians of the EMR software for ongoing communication with our PCP practices (the PCP Practices must be using the software for this communication). Implementation of this methodology would eliminate the need for a manually generated Daily Report. The Hospitalists and our EMR software team are now communicating and working together to investigate what it will take to make this happen, rather than discussing whether or not it needs to happen. We are hopeful that with continuing teamwork, the ability for two-way electronic communication including tasking and e-prescribing will take place in the June-July 2011 timeframe.

Initially, five primary care practices were identified and enthusiastically agreed to become part of the Transitions of Care Pilot. These practices represent a variety of types of primary care practices and entered the Pilot Project with a high degree of commitment to improve patient care provision. All of them are participants in a project jointly delivered by the Center for the Advancement of Primary Care and Medical Management Operations, called the “Collaborative Project.” This project assesses and advances PCMH functionality, with a focus on patients with chronic illnesses such as diabetes, hypertension, and coronary artery disease.

Having seen success through the Collaborative project, the Transitions of Care participating practices have become champions for expanded practice innovation and evolution. The "Championship" of the existing participating Primary Care Practices, has excited other PCP offices to want to join this project. We are currently involving a sixth PC practice with two others expected to join in the coming months.

Each participating practice has an assigned Practice Improvement Facilitator (PIF). These facilitators work in a coordinated manner helping the practices implement agreed upon workflows, processes, and procedures in support of this Pilot Project. Each practice has step-by-step processes and associated work flow diagrams to implement agreed upon procedures.

We initially began our Pilot Project on the Hospitalist Medicine Service at Memorial Hospital. Since then we have expanded our Pilot to cover participating Primary Care Physician patients admitted to the Memorial Orthopedic Service and patients admitted to the University Campus Hospital Medicine Service. With this expansion, we cover a large percentage of all admitted patients of the participating Primary Care Practices.

Our work supports ongoing communication and collaboration among the members of the Pilot Project Team. We utilize weekly meetings, telephone conversations, and email to continually work together ensuring information and knowledge is transferred from the person who has it to those people who need it.

Weekly meetings were held from early January 2010 and continue to be held every Monday for one to one and one-half hours. These weekly project leadership meetings allow time to discuss progress, status, risks, dependencies, and to resolve open issues. For every meeting an agenda is created.
and distributed at least 48 hours in advance. Additional meetings are held as needed to resolve issues.

The success of our Pilot Project Team led to our ability to hold a successful Project Kickoff. On June 23, 2010 we held the Project Kickoff attended by 19 professionals. During the Kickoff, physicians from the Hospitalist Team and the Primary Care Physician Practices presented details of the Pilot Project to a very engaged audience, generating lots of interactive discussion. The Kickoff was held in preparation for a July 12, 2010 Go Live date.

Our ability to work together in a cohesive unit focused on the goals and objectives of this important Pilot Project resulted in a successful Go Live during the week of July 12, 2010. During this week, we began implementation of the processes, procedures, and workflows that resulted from many weeks of dedicated planning.

As described in the Workflow spreadsheets, project flow diagrams, and project plans, the Hospitalist teams gathered data daily and distributed that patient related data to various PCP Practices. Follow up with the PCP Practices was monitored by Practice Improvement Facilitators and issues were responded to as quickly as possible.

To ensure success, our team agreed to utilize a phased project plan. The importance of this approach cannot be overstated. Rather than implement a large scale plan all at once, we determined that our greatest chance of success involving change management, requires that we move ahead in a step wise or phased plan.

Phase I of the project plan included all pre-implementation activities including design of work flow diagrams, documentation of policies, processes, procedures, and IT requirements. Phase I included five primary care practices (20+ Primary Care Physicians) and the Hospitalist Team on the Memorial Medicine Service.

Phase II allowed us to expand the project to include Memorial Orthopedic admissions of the 20+ primary care physicians participating in this project. This began in October and was a very smooth and successful expansion.

Phase III allowed us to move the University Campus covering patients of the 20+ participating Primary Care Physicians admitted to the hospital and covered by the University Hospitalist Medicine Service. With the expansion to University Hospitalist Medicine Service, we now cover a large majority of the 20+ participating Primary Care Physicians' patient admissions.

Phase IV has expanded PCP participation to include one additional practice and we will be adding two more practices in the short term.

**Identify Goals Not Achieved**

One goal not yet achieved, is the addition of two more Primary Care Practices to our list of participating practices. We are actively working to identify two additional practices and hope to accomplish this within the April – June 2011 timeframe.

A second goal not yet achieved is the acceptance and implementation of our new Case Management form that includes Risk Assessment. This form has been approved by Legal and is in review in our Forms Committee.

**Plan for Extending and Sustaining Achievements Beyond the Grant Year**

The importance of transitions of care from hospital to outpatient settings cannot be overstated. Smooth transitions have been shown to potentially reduce readmissions and serve to facilitate patient comfort, satisfaction, and recovery. Therefore UMMHC, recognizing the ongoing importance of investigation into evolutionary implementation of transitions, has formed a system wide Transitions of Care Steering Committee. This effort will focus on bringing together all professionals with knowledge and information gained from various activities including all Transitions of Care Pilots. The focus of this effort is to analyze what we know about readmissions in each of our participating hospitals, what has been learned from our project efforts and collaboratively plan a transition of care approach for UMass Memorial Healthcare.
This effort will bring together experts and champions from BOOST, H2H, STAAR, and our Transitions of Care Project. Presentations will be made and we will be introduced to the new case management patient risk assessment tool. This tool was created by our Transitions of Care team members working collaboratively with Case Management professionals. The form was the result of our work in our Transitions of Care Project and utilizes the most up to date, state of the art, capability for assessing risk.

We expect the major focus of transitions of care to be the goal of this cross-functional team as the efforts become consolidated into one program in the months ahead.

We are pleased to list 10 lessons learned from our Transitions of Care Pilot Project. Although much of what you read below is about communication, the communication differs considerably and each is as important as the rest. We hope that as you read our lessons learned, you will find some “words of wisdom” to apply on your own transitions of care or other projects.

1. Planning and coordination are absolutely critical components of a project that focuses on coordination and transitions of care
   a. Before you start an effort like this, identify your team, and agree on a charter that includes goals, objectives, project plans (MS Project), roles, responsibilities, escalation processes, communication plans, training plans, and success criteria

2. Communication: It has been said before, but needs to be said again and again; communicate.
   a. Meet in person, virtually, by telephone, send emails, but make sure no matter what you share information and knowledge and keep each other informed as much as possible.
   b. We held weekly team meetings, weekly reports, and work groups, throughout the project to ensure everyone was up to date and “on the same page.”
   c. Minutes from every meeting contained discussion topics, descriptions of activities, action items, dates of delivery and ownership of required activities.

3. Practice involvement: Regardless of weather, or other variables, make sure you meet face-to-face with the practices on an ongoing basis.
   a. The deep commitment and involvement of our Practice Improvement Facilitators was a critical success factor in this project. PIFs met with the practices and kept team members informed about issues or potential issues while working to resolve them.

4. Human Involvement: Along with communication and practice involvement, the human element in the preparation, in the absence of electronic means, of the Daily Report was extremely important for this project.
   a. Our Hospitalist Secretary responsible for generation of the Daily Report was instrumental in collecting, aggregating, and distributing a report that repeatedly made the lives easier for our Hospitalists, Primary Care Physicians. By this work, our patients’ transition from hospital to outpatient was improved.

5. Survey Participating Physicians: Important throughout a project like this is the ability to keep all physicians involved and examine the value of what you are doing through their eyes and with their perspective.
   a. We involved the Hospitalists and Primary Care Physicians continually gathering input from them and dispensing their feedback to others.
   b. We did a “formal” survey of Hospitalists and Primary Care Physicians speaking by telephone to a number of participating physicians to understand where they saw value in the project, what they would change, and the impact the project was having.
on their practices. Results of this set of powerful interviews, is leading to important changes in transitions of care such as our next lesson learned…

### 6. Consensus Building:

It is very important for people to see value in what they are doing while making sure that value relates back to improving their work flow and business processes.

- At the beginning of the project, most of the participating PCPs asked that the Hospitalists use the electronic medical records system they were already using. There was much discussion over the course of many months as to why this was/was not feasible and for many very appropriate reasons.

- Gaining consensus over time, allowed everyone to begin to think about and talk about what it would mean to each other, not just one group or the other, to investigate having Hospitalists using the same EMR that our PCPs are using.

- We are now in discussions around what it would take to make this possible; something that ranked high on the “wish list” of almost every participating Primary Care Physician in our Pilot Project.

### 7. Sensitivity:

Of course we are all sensitive to others, but to varying degrees. In our Transitions of Care Pilot Project, we keep forefront in our minds that we were working with busy physicians who are extraordinarily dedicated to patient care delivery.

- We would remind everyone, including ourselves, that our doctors’ primary focus is on their patients and that if they could not make meetings, etc. we needed to be sensitive to their needs and flexible enough to work with them to meet our joint goals for success.

### 8. Set Success Criteria:

Set success criteria at the beginning of the project. Should this even be mentioned? It is obvious that projects need to do this right? Wrong.

- We found three sets of success criteria mapped to what our audiences wanted out of this project and we worked to tailor our success criteria so that each will get most of what they need in the way of data and performance measurements from our collaborative teamwork.

### 9. Develop Escalation Processes:

Every project runs into difficulty now and then and without pre-established and even more so, agreed upon escalation processes, you will most likely run into more difficulty than should happen.

- We did our best to put escalation processes in place prior to starting our project. For example, the Head of the Hospitalists made it very clear that if the participating PCPs had issues with anything, they needed to send him an email or better yet call him to get their issues resolved. This demonstrated his commitment to the PCPs and several took him up on it and they were able to resolve what could have been very, very difficult discussions.

### 10. Patience and Persistence:

We found that change occurs in small steps and that it is absolutely a process. Very little, if anything happens instantaneously.

- Affecting change, even small changes, in organizations where things have been done specific ways (or no way) for long periods of time can be difficult. You can decide just to give up OR…

- You can try week after week, little bit by little bit, to be part of the solution.

- As one Manager continues to say, "Patience and persistence…"

- As one Hospitalist says, “it’s a process…"
Transitions of Care Project – Performance Measurement

From July 12, 2010 through February 23, 2011 we tracked admissions of over 700 patients from the patient population described above. Our project rolled out in phases such that:

- **Phase I** – July 12, 2010 – October 2010 patients admitted to the Memorial Hospitalist Medicine Service were tracked
- **Phase II** – In October 2010 we added patients admitted to the Memorial Orthopedics Service (Ortho only, no Spine patients)
- **Phase III** – On February 7th 2011, we began tracking patients admitted to the University Hospitalist Medicine Service
- **Phase IV** – Three additional practices will be added beginning March 2011

Since the beginning of our project, July 12, 2010, we have tracked patient admissions of the Primary Care Physicians in our study covered by the services listed above. We are tracking patients who were discharged to home or home with services. As of February 25, 2011 71.6% of patients in our Pilot Project who were admitted and tracked, as part of our study, went home or home with services.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Result</th>
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<tbody>
<tr>
<td><strong>Performance Measure #1:</strong> 30 day readmission rate</td>
<td><img src="image" alt="STAAR 30 Day All Cause Readmission Rate" /></td>
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</table>
| **Performance Measure #2 and #3:** H-CAHPS Scores | Data Source: H-CAHPS scores  
Data Submission: Measurement Period: January 2010 – December 2010  
Question Asked:  
HCAHPS – Received information re: symptoms to look for | 90.96% (n=741)  
HCAHPS – Talked about help you would need | 90.22% (n=736)  
Composite Score | 90.59% |
**Performance Measure #4:**

<table>
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<th>% of target population</th>
<th>We estimate that 95% of our participating Primary Care Physicians received Patient Discharge Information (PDI) within 48 hours of patient discharge from hospital. Reasons why some of our patients did not have a PDI at discharge received by the PCP may include, but are not limited to:</th>
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| for whom PCPs receive discharge summary | 1. Patient stay was of shorter duration than required for PDI generation  
2. In very rare cases no PDI was generated for unknown reasons  
3. PDI may have been written, but not posted electronically and therefore not accessible to be considered “received” by the PCP |

During the course of this project, we were privileged to work with Case Management and Consultants to Case Management in the creation of a Care Management Risk Assessment process. A new Case Management form was designed based on the latest healthcare industry research with a focused Risk Management Assessment section. Currently, the form is in review committee and therefore was not implemented during this project’s timeline. However, we understand as of this writing, the form has received Legal approval, and is in review in the Forms Committee.

Although we are able to provide information on part of this measure, we are unable for reasons stated, to provide a full measure of patient follow up in compliance with post discharge follow up based on risk stratification protocol. We estimate that approximately 50% of target patient population was seen by their PCP in compliance with post discharge follow up. Reasons why some of our patients were not seen in compliance with post discharge follow up may include, but are not limited to:

1. Patient saw a specialist first, prior to seeing a PCP and this visit made the visit to the PCP unnecessary during the recommended time period.  
2. During the 48 hour post-discharge phone call by the PCPs office to the patient, there may have been a change of plan for the patient – the patient may have been seen later, rather than sooner or sooner rather than later.  
3. Patient may have been readmitted to the hospital requiring a change of care plan by the PCP for the patient  
4. Patient may have been transferred to another service necessitating a change of care plan by the PCP for the patient. |

We therefore estimate that approximately 50% of our participating target population was seen by their PCP in compliance with post discharge follow up based on risk stratification protocol whose post discharge contact included medication reconciliation, assessment of patient knowledge, and assessment of patient self-management capacity. Reasons why this did not occur may include, but are not limited to:

1. List of reasons considered for “%of target population seen by their PCP in compliance with post discharge follow up”  
2. No Risk Assessment tool available in time for implementation by this Pilot Study |