Transitions

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*Et al.*

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INTRODUCTION
The Patient-Centered Medical Home (PCMH) offers an innovative model of care: comprehensive primary care, quality improvement, care management, and enhanced access in a patient centered environment.

AIMS
Objective 1: Identify hospital discharge follow-up as a core clinical process in patient-centered medical home transformation.
Objective 2: Anticipate common barriers to the implementation of hospital discharge follow-up workflows and processes.
Objective 3: Develop specific strategies and tools to address anticipated barriers to the implementation of hospital discharge follow-up processes in your setting, to ensure consistent coordination of care across multiple care sites.

BACKGROUND
Massachusetts Patient-Centered Medical Home Initiative
- Multi-payer, statewide initiative
- Sponsored by Massachusetts Health and Human Services; legislatively mandated

Sequencing:
Build the Home from the Foundation Up
- 46 participating practices
- 2-year demonstration: March 2011 – March 2014
- Includes payment reform and technical assistance

System for Identifying Highest-Risk Patients
- Registry Reports
  - Practice Registry Reports
  - Health Plans Monthly List
- Frequent ED Visits
- The Care Team’s List

Domains of Care Management Activities and Services
- Transitions of Care
- Management of Chronic Conditions
- Medication Reconciliation
- Patient Self Management and Self Care Skills and Wellness
- Exacerbation Management
- Frequency of Monitoring and Follow-up

Methods: Quantitative Analysis
- **Design:** Quality improvement study using practices’ self-reported monthly data on clinical care coordination measures from June 2011 through February 2014
- **Method:** Linear Mixed Model
- **Analysis:** Data were divided into three-month periods:
  - Baseline (September 2011 – November, 2011) to Time 10 (December, 2013 – February, 2014)
  - Analysis of Change over Time: Baseline vs. Time 10

Methods: Qualitative Analysis
- **Design:** Qualitative study using practices’ self-reported data on key concepts of the medical home model and on practices’ monthly transformation activities including barriers and successes
- **Method:** Document studies using narratives from PCMH transformation reporting tool
- **Analysis:**
  - Focusing on topics related to care coordination activities
  - Emphasized common themes across practices on issues in hospital discharge follow-up

Results: Quantitative
Care Coordination/Care Management Measures: Change over Time

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>Time 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up After Hospital Discharge</td>
<td>63.3</td>
<td>66.5</td>
</tr>
<tr>
<td>Care Plans for Highest-Risk Patients</td>
<td>36.1</td>
<td>64.7</td>
</tr>
</tbody>
</table>

Results: Qualitative
Success:
- Prioritizing high volume hospital systems for information sharing
- Streamlining documentation of the workflow in the electronic health record
- Focusing on highest-risk patients as evidenced by utilization
- Clearly identifying the role and function of each care team member in the new process

Barriers:
- Inconsistent staffing
- The challenges of information-sharing across various sites of care

Follow-up After Hospital Discharges Change Over Time for 8 Practices

<table>
<thead>
<tr>
<th>Practice</th>
<th>Baseline</th>
<th>Time 10</th>
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</thead>
<tbody>
<tr>
<td>Practice #1</td>
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<td>48.5</td>
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<td>Practice #2</td>
<td>10.3</td>
<td>40.5</td>
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<td>43.1</td>
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<td>Practice #6</td>
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<td>55.4</td>
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<td>Practice #7</td>
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<td>67.4</td>
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<td>Practice #8</td>
<td>81.1</td>
<td>100</td>
</tr>
</tbody>
</table>

Aggregate Average Number of Hospitalizations Identified by Practices During Each Time Period

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Number of Hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>71</td>
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<tr>
<td>3 Months</td>
<td>61</td>
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<tr>
<td>6 Months</td>
<td>71</td>
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<tr>
<td>9 Months</td>
<td>107</td>
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<tr>
<td>12 Months</td>
<td>106</td>
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<tr>
<td>15 Months</td>
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<td>18 Months</td>
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<td>21 Months</td>
<td>112</td>
</tr>
<tr>
<td>24 Months</td>
<td>129</td>
</tr>
<tr>
<td>27 Months</td>
<td>132</td>
</tr>
</tbody>
</table>

CONCLUSION
- Primary care practice transformation takes time
- Care transitions including ER or post discharge follow-up require the development of new clinical workflows
- Processes of care are more likely to improve before outcomes are impacted
- In the context of national efforts to increase the value of health care delivery, the lessons learned from this model can be valuable to provider organizations who take on clinical and financial risk:
  - Focusing on highest-risk patients
  - Prioritizing high volume hospital systems for information-sharing
  - Streamlining documentation of the workflow in the electronic health record
  - Clearly identifying the role and function of each care team member in the new process

Lessons Learned: Strategies for Follow-up After Hospitalization
- Develop notification system with key hospitals that alerts practice to discharges same day and forwards discharge plan
- Develop tracking system for discharges that includes:
  - Date of discharge
  - Date of transition call
  - Assessment, Plan of Care, Follow-up Plan
- Develop communication system with primary care provider regarding discharged patient assessment and plan of care/follow-up

Lessons Learned: Strategies for Developing Patient Plan to Prevent Re-Hospitalizations
- Opportunity to assess baseline understanding of patient knowledge
- Opportunity for education intervention
- Opportunity to schedule follow-up appointment

SUMMARY
- At the close of the MA PCMH Initiative (3 years), clinical measures related to follow-up after hospital discharge showed improvement
- Eight individual practices showed significant improvement across time
- The average number of hospital follow-up encounters per measurement period more than doubled over the span of the Initiative, dramatically increasing the opportunity for coordination of care for patients during this important transition
- Improvement in:
  - Communication infrastructure between practices and hospitals
  - Ability of practices to track and report on their clinical processes

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