Practice Name
Address
City, State Zip
Phone

CC 14 through 19

Draft 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.>
2. Standard documentation provided to hospital for admission <summaries, referrals, notes, reason, special requests, admit orders, shared EHR, etc.>

CC 15
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.>

CC 18
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.>

CC 17
5. After-hours information exchange <on-call provider, 24/7 access to EHR, phone calls, etc.>

C. Hospital Discharge

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

CC 14
1. Notification of discharge from hospital
   a. Discharge list from hospital (or plans) <push by hospital/plans, pull by practice, combination, etc.>

CC 19
   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>

CC 16
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>

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.>

CC 18
3. Information sent <notes, test results, meds, allergies, phone consultation>
4. Information exchange <electronic, fax, HIE, phone, in-person consults, etc.>

E. ED Discharge

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

CC 14

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>

CC 19

   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>

CC 16

3. Time frame for follow up <XX days after discharge>

Approved By:

Effective: 6/15/2017
Revised:

Other areas for practice consideration:

1) **OHIC cost management strategies:** As practices develop and implement Transition of Care Policies and work flows, practices will want to refer to the current OHIC cost management strategies that provide added time frame requirements. Eighty percent of the cost management strategies must be met by October of your 3rd year in the CTC contract. Note: OHIC cost management strategies may be updated on a regular basis and requirements increase based on number of years a practice has been in a transformation program.

Cost Management Requirement	Deeming option	Transformation Yr.		
6. For high-risk patients known to be hospitalized or in a SNF, the Care Management/Care Coordination resources shall contact the patient and/or the hospital discharge planner and begin transition-of-care planning at least 24-hours prior to the patient's discharge.	NCQA: either 2011 or 2014 NCQA PCMH 5, Element C is met AND the practice is beginning TOC planning within the required timeframe.		X	X
7. The Care Management/Care Coordination resources contact every high-risk patient who has been discharged from hospital inpatient services after discharge to determine care management needs. • Year 1: within 72 hours after discharge. • Years 2 and 3: within 48 hours after discharge.	NCQA: requirement is deemed met if 2011 or 2014 NCQA PCMH 5, Element C is met AND the practice is meeting the specific timeframe for completing the outreach contacts. TCPI: requirement is deemed met if Phase 3 N is achieved.	X	X	X
8. The Care Management/Care Coordination resources contact every known high-risk patient who has had an Emergency Department visit for a situation or condition that is related to or contributes to the patient's high-risk status. • Year 1: within 72 hours of an ED visit. • Years 2 and 3: within 48 hours of an ED visit.	NCQA: requirement is deemed met if 2011 or 2014 NCQA PCMH 5, Element C is met AND practice is meeting the specific timeframe for completing the outreach contacts. TCPI: requirement is deemed met if Phase 3 N is achieved.	X	X	X

Cost Management Requirement	Deeming option	Transformation Yr.		
9. The Care Management/Care Coordination resources complete medication reconciliation after a high-risk patient has been discharged from inpatient services; to the extent possible the medication reconciliation is conducted in person. • Year 1: within 7 days of discharge. • Years 2 and 3: within 72 hours of discharge.	NCQA: requirement is deemed met if 2011 NCQA PCMH 3, Element D or 2014 NCQA PMCH 4, Element C is met AND the practice is meeting the specific timeframe for completing the medication reconciliations. TCPI: requirement is deemed met if Phase 2 F is met AND the practice selected medication management review as	X	X	X

2) Transition from pediatric to adult:

Based on practice type, transitions of care can additionally include development and implementation of a written care plan for young adults and adolescent patients with complex needs transitioning to adult care; see resource document "Incorporating Pediatric to Adult Transitions into NCQA PCMH .

Practices electing this care coordination and care transitions competency "credit" will want to be able to document evidence of implementation.

2017 NCQA PCMH Standards		Six Core Elements Tools
Criteria	Guidance	
5. Care Coordination and Care Transitions (CC)		

CC 20 (1 Credit): Collaborates with the patient/family/caregiver to develop/implement a written care plan for complex patients transitioning into/out of the practice (e.g., from pediatric care to adult care).	*Guidance:* The practice involves the patient/family/caregiver in the development or implementation of a written care plan for young adults and adolescent patients with complex needs transitioning to adult care. The written care plan may include:
	• A summary of medical information (e.g., history of hospitalizations, procedures, tests).
	• A list of providers, medical equipment and medications for patients with special health care needs.
	• Obstacles to transitioning to an adult care clinician.
	• Special care needs.
	• Information provided to the patient about the transition of care.
	• Arrangements for release and transfer of medical records to the adult care clinician.
	• Patient response to the transition.
	• Patient transition plan.
	Internal medicine practices receiving patients from pediatricians are expected to request/review the transition plan provided by pediatric practices or develop a plan if one is not provided to support a smooth and safe transition.
	For family medicine practices that do not transition patients from pediatric to adult care, should still educate patients and families about ways in which their care experience may change as the patient moves into adulthood. Sensitivity to privacy concerns should be incorporated into messaging.
		• Sample Transfer Letter
		• Sample Medical Summary and Emergency Care Plan
		• Sample Plan of Care
		  ○ Peds
		  ○ FM/Med-Peds
		  ○ IM
		• Sample Transition Readiness Assessment
		  ○ Peds (for youth or for parents/caregivers)
		• Sample Transition Policy
		  ○ FM/Med-Peds
		• Sample Health Care Transition Feedback Survey
		  ○ Peds (for youth or for parents/caregivers)
		  ○ FM/Med-Peds (for youth/young adults or for parents/caregivers)
		  ○ IM (for young adults)
		• Sample Welcome and Orientation of New Young Adults