SIM Subcommittee Report to SIM Steering Committee

Transitions of Care (TOC)

Definition: Transition of Care – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory, specialty care practice, psychiatric, long-term care, home health, rehabilitation facility) to another. The initial scope is focused on "post-acute care transitions," specifically addressing patient documentation for transitions across inpatient-hospital to long-term care/SNF, home health to home/community.

Goal of Subcommittee: Support Transitions of care focusing on maximizing health outcomes to MaineCare members and managing high costs for the MaineCare program. Develop a standard approach by: 1) Determining how data can be used effectively to improve transitions of care; 2) Developing a standard approach across organizations for transitions of care.

Develop statewide strategy for either one TOC form and/or extraction of data elements from submitted forms to HIE. Resources are needed to create this project.

Transitions of Care Data content and scope

1) TOC to include and expand on key data currently available within the HIE.
   - Problems/Diagnosis; consider how to group medications by correlating problem/diagnosis
   - Patient/provider goals related to the "plan of care"
   - Risks or barriers to achieving patients goals
   - Medication information, as much as possible
   - Facility/Encounter info: such as the contact information of organizations providing services to patient
   - Primary Care Provider
2) Medical information expansion priorities:
   - Post-acute care; Long-Term Care, Hospice/Home Health
   - Community Care Team (CCT) data when not part of Primary Care EHR's already sending data
     - Housing needs and resources, Transportation needs and resources, Food/nutrition needs and resources
   - Behavioral Health services focused on SPMI/Chronic Disease/Primary Care integration
   - Additional reports/documents to be sent from the EHR's/centralized data systems
   - Risk related Assessment & Screening documents
     a. Fall risk documentation
     b. Functional status assessments
     c. Behavioral Health/Crisis plans
     d. Long-term care assessments
   - Care Plan documents that include patient goals and risks to those goals
     a. Post-acute care
     b. CCT's
     c. Behavioral Health
     d. Primary care
   - End of life documents
     a. Advanced Directives
     b. Physician Order for Life Sustaining Treatment (POLST) forms

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