<table>
<thead>
<tr>
<th>NUMBER</th>
<th>SCENARIO</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hospitalist discharges patient from community hospital to home after pneumonia</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Patient makes appointment (self-referral) to a specialist</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>Hospital discharge of 86 year-old patient to SNF after surgery for hip fracture</td>
<td>4</td>
</tr>
<tr>
<td>11</td>
<td>PCP refers patient to specialist</td>
<td>5</td>
</tr>
</tbody>
</table>
Matrix Table “B” lists any number of Scenarios, which are use cases for care transitions. Each case is represented as a table containing problems and solutions. Anyone might submit a new case to the scenario database.

This document contains four examples extracted from the master Table “B” which has additional scenarios.

<table>
<thead>
<tr>
<th></th>
<th>Elements</th>
<th>Details</th>
<th>Failure modes, risks, barriers</th>
<th>Supportive materials, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Initiator</td>
<td>Hospitalist determines patient is ready for different level of care and writes an order. Nurse determines patient is ready for discharge and requests a physician order.</td>
<td>Delayed follow-up with provider; follow-up left to patient alone</td>
<td>RARE Campaign: <a href="http://www.rarereadmissions.org/">www.rarereadmissions.org/</a></td>
</tr>
<tr>
<td>B</td>
<td>Receiver</td>
<td>Patient, family, PCP</td>
<td>No follow-up appointment scheduled; patient unclear about who, when, why</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Transport carrier</td>
<td>Private car</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Human payload</td>
<td>Patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Other (physical) payload</td>
<td>Medications, property, equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Information payload</td>
<td>Physician prepares D/C instructions &amp; summary Nurse provides care plan, med administration log, property log</td>
<td>Discharge summary does not accompany patient; no “discharge package” (e.g., emergency contact, prescriptions, follow-up, warnings)</td>
<td>Written summary, patient portal</td>
</tr>
<tr>
<td>G</td>
<td>Communication medium &amp; mode</td>
<td>Verbal, paper</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The application “FIND” function allows searching for any term or phrase.

The Value of solutions can be expressed in terms of HIMSS Value STEPS (Satisfaction, Treatment/Clinical, Electronic information/data, Prevention & Patient Education, Savings); regulatory/legal compliance (e.g., Meaningful Use, HIPAA); patient safety, privacy; risk management; etc.

Matrix Table “A” (Elements) lists the logical components of a care transition.
### 1. Hospitalist discharges patient from community hospital to home after pneumonia

<table>
<thead>
<tr>
<th>Element (from Table A)</th>
<th>Details</th>
<th>Failure modes, risks, barriers</th>
<th>Supportive materials, standards, references, guidelines, best practices, resources, links</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>Tasks &amp; contingencies</td>
<td>Follow up by patient; follow-up by providers; prescriptions transmitted and picked up; arrangements for home O2</td>
<td>Patient not clear about follow-up plan; contingency plans; no provision for O2 at home until after the weekend</td>
</tr>
<tr>
<td>I</td>
<td>Authorization</td>
<td>Normal</td>
<td>Nobody in charge; no case manager; patient has impression “things are under control”</td>
</tr>
<tr>
<td>J</td>
<td>Voluntariness</td>
<td>Normal</td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>Complexity</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>Latency</td>
<td>Minimal</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>Priority</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Notices, acceptance, acknowledgement</td>
<td>Paperwork with patient, electronic notification to PCP, claim to insurance</td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>Documenting the transition</td>
<td>EHR</td>
<td>Delay in recording D/C summary</td>
</tr>
<tr>
<td>P</td>
<td>Status tracking</td>
<td>Complete</td>
<td></td>
</tr>
</tbody>
</table>

### 2. Patient makes appointment (self-referral) to a specialist

<table>
<thead>
<tr>
<th>Element (from Table A)</th>
<th>Details</th>
<th>Failure modes, risks, barriers</th>
<th>Supportive materials, standards, references, guidelines, best practices, resources, links</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Initiator</td>
<td>Patient senses a medical problem and presents to a healthcare entity.</td>
<td>Did not bring necessary information; unprepared for visit/procedure (e.g., bowel prep); wrong specialty selected; specialist is out-of-network</td>
</tr>
<tr>
<td>B</td>
<td>Receiver</td>
<td>Specialist (e.g., dermatology, neurology, etc.)</td>
<td>Did not receive necessary information (e.g., care plan, meds, reason for visit); cannot provide expected service</td>
</tr>
<tr>
<td>C</td>
<td>Transport carrier</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Human payload</td>
<td>Patient with arthritis</td>
<td>Mobility</td>
</tr>
<tr>
<td>E</td>
<td>Other (physical) payload</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Information payload</td>
<td>Current concern (reason for visit), past medical history, demographic data, insurance data</td>
<td>No records available; patient unable to list past providers; takes 9 weeks to obtain records; lack of interoperability w/PHR; lack of pre-visit package</td>
</tr>
</tbody>
</table>
## Care Transition Scenarios

### 2 Patient makes appointment (self-referral) to a specialist

<table>
<thead>
<tr>
<th>Element (from Table A)</th>
<th>Details</th>
<th>Failure modes, risks, barriers</th>
<th>Supportive materials, standards, references, guidelines, best practices, resources, links</th>
</tr>
</thead>
<tbody>
<tr>
<td>G</td>
<td>Communication medium &amp; mode</td>
<td>Verbal; phone; e-message</td>
<td>Electronic portals; messaging</td>
</tr>
<tr>
<td>H</td>
<td>Tasks &amp; contingencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>Authorization</td>
<td>Patient initiated</td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>Voluntariness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>Complexity</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>Latency</td>
<td>Short</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>Priority</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Notices, acceptance, acknowledgement</td>
<td>Verbal</td>
<td>Scheduling error</td>
</tr>
<tr>
<td>O</td>
<td>Documenting the transition</td>
<td>Provider EHR; patient PHR</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Status tracking</td>
<td>Pending</td>
<td></td>
</tr>
</tbody>
</table>

### 8 Hospital discharge of 86 year-old patient to SNF after surgery for hip fracture

<table>
<thead>
<tr>
<th>Element (from Table A)</th>
<th>Details</th>
<th>Failure modes, risks, barriers</th>
<th>Supportive materials, standards, references, guidelines, best practices, resources, links</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Initiator</td>
<td>Orthopedic surgeon’s Physician Assistant</td>
<td>Never met the patient before making rounds this morning</td>
</tr>
<tr>
<td>B</td>
<td>Receiver</td>
<td>Charge nurse at SNF</td>
<td>Overworked</td>
</tr>
<tr>
<td>C</td>
<td>Transport carrier</td>
<td>Ambulance</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Human payload</td>
<td>Patient</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Other (physical) payload</td>
<td>Walker, paperwork, personal property</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Information payload</td>
<td>Admission H&amp;P, Op-note, D/C summary, Form LTC 101; Durable Power of Attorney</td>
<td>H&amp;P has inaccuracies, Op-note not dictated yet, D/C Summary sparse, Transfer Form lists meds inaccurately; Transfer Form has too little space for necessary information; DPOA does not accompany patient</td>
</tr>
<tr>
<td>G</td>
<td>Communication medium &amp; mode</td>
<td>Verbal (phone) sign-out, paperwork</td>
<td>Hospital portal is cumbersome to use</td>
</tr>
</tbody>
</table>
### 8 Hospital discharge of 86 year-old patient to SNF after surgery for hip fracture

<table>
<thead>
<tr>
<th>Element (from Table A)</th>
<th>Details</th>
<th>Failure modes, risks, barriers</th>
<th>Supportive materials, standards, references, guidelines, best practices, resources, links</th>
</tr>
</thead>
<tbody>
<tr>
<td>H Tasks &amp; contingencies</td>
<td>Rehab until fit for D/C home; manage multiple active medical conditions in addition to rehab</td>
<td>Does not have good communication channel with surgeon to report concerns; no communication with multiple other specialists (e.g., neurology, cardiology, nephrology)</td>
<td></td>
</tr>
<tr>
<td>I Authorization</td>
<td>Routine</td>
<td>No care coordinator</td>
<td></td>
</tr>
<tr>
<td>J Voluntariness</td>
<td>Reluctant consent; possibly confused</td>
<td>Nothing to do; everybody hates nursing homes for valid reasons</td>
<td></td>
</tr>
<tr>
<td>K Complexity</td>
<td>Low</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L Latency</td>
<td>Short</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M Priority</td>
<td>Standard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N Notices, acceptance, acknowledgement</td>
<td>Phone sign out; faxes sent to numerous providers</td>
<td>PCP not notified about the transfer; no notice back to hospital on arrival; family supposed to be notified by hospital but nurse was not able to reach by phone; faxes went out a week after discharge</td>
<td>Portals could have patient status tracking function with Push notifications to authorized subscribers.</td>
</tr>
<tr>
<td>O Documenting the transition</td>
<td>Hospital EHR, SNF EHR</td>
<td>Dual data entry; no direct exchange</td>
<td>Standard message format</td>
</tr>
<tr>
<td>P Status tracking</td>
<td>On route</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 11 PCP refers patient to specialist

<table>
<thead>
<tr>
<th>Element (from Table A)</th>
<th>Details</th>
<th>Failure modes, risks, barriers</th>
<th>Supportive materials, standards, references, guidelines, best practices, resources, links</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Initiator</td>
<td>Family practitioner</td>
<td>Doesn’t know if specialist is in network; portals are difficult to use</td>
<td>Network affiliation available in EHR; Insurance carrier portal; specialist portal</td>
</tr>
<tr>
<td>B Receiver</td>
<td>Cardiologist</td>
<td>Does not speak Russian</td>
<td>Translation service</td>
</tr>
<tr>
<td>C Transport carrier</td>
<td>Private car</td>
<td>Don’t know directions to office</td>
<td>GPS; portals</td>
</tr>
<tr>
<td>D Human payload</td>
<td>Patient and daughter</td>
<td>Patient speaks Russian; daughter’s English is less than fluent</td>
<td>Translation service</td>
</tr>
<tr>
<td>E Other (physical) payload</td>
<td>Asked to bring “all your meds”</td>
<td>Do not bring medications</td>
<td>PHR</td>
</tr>
</tbody>
</table>
### Care Transition Scenarios

#### PCP refers patient to specialist

<table>
<thead>
<tr>
<th>Element (from Table A)</th>
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<th>Failure modes, risks, barriers</th>
<th>Supportive materials, standards, references, guidelines, best practices, resources, links</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>F</strong> Information payload</td>
<td>Current concern (reason for visit), past medical history, demographic data, insurance data</td>
<td>Patient does not have necessary records; unprepared for visit/procedure (e.g., fasting overnight); portals are cumbersome – specialist does not have time to access info</td>
<td>Portable PHR; PCP portal</td>
</tr>
<tr>
<td><strong>G</strong> Communication medium &amp; mode</td>
<td>In person</td>
<td>Language barrier</td>
<td>Translation service</td>
</tr>
</tbody>
</table>
| **H** Tasks & contingencies | Address concerns; evaluation and management | Visit ineffective:  
- Doctor didn’t hear or respond to the active concern  
- Patient didn’t absorb, understand or accept the explanation or advice  
- A critical test, result or resource was not available; or action was deferred because of:  
  - poor coordination of resources  
  - poor communication between providers  
  - lack of foresight or planning  
- The patient referred to wrong doctor, facility or program; or received the wrong test or information  
- Diagnosis or treatment proposed made no sense to the patient, or had already been tried  
- Obvious errors apparent in data collection or communication | See “Medical School” |
| **I** Authorization | Shared decision making | Daughter disagrees |
| **J** Voluntariness | Patient is conscious and competent | Daughter mistranslates and introduces bias |
| **K** Complexity | Moderate |
| **L** Latency | None |
| **M** Priority | Moderate |
| **N** Notices, acceptance, acknowledgement | Verbal |
### 11 PCP refers patient to specialist

<table>
<thead>
<tr>
<th>Element (from Table A)</th>
<th>Details</th>
<th>Failure modes, risks, barriers</th>
<th>Supportive materials, standards, references, guidelines, best practices, resources, links</th>
</tr>
</thead>
<tbody>
<tr>
<td>O Documenting the transition</td>
<td>Office scheduling system; provider EHR; visit summary; billing/claim history</td>
<td>No visit summary; claim does not match service</td>
<td></td>
</tr>
<tr>
<td>P Status tracking</td>
<td>Complete</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>