Primary Care Transitions Change Package

August 2013

Principal Investigator: Darren A. DeWalt, MD, MPH

Authors:
The Cecil G. Sheps Center for Health Services Research
Darren A. DeWalt, MD, MPH
Kristie W. Thompson, MA

The North Carolina Area Health Education Centers Program
Samuel Cykert, MD
Laura Brown, MPH

Community Care of North Carolina
Jennifer Cockerham, RN, BSN, CDE

Table of Contents

Acknowledgements

Thomas J. Bacon, DrPH
Former Executive Associate Dean, School of Medicine
Former Director, NC Area Health Education Centers Program,
    UNC Chapel Hill

Jamie Barnes RN, MBA
Executive Director
Community Care of Southern Piedmont

Sonali Batish, MPH
QIC/REC Team Lead
Regional Extension Center
South East Area Health Education Center

Laura Brown, MPH
Quality Improvement Manager
NC Area Health Education Centers Program
UNC Chapel Hill

Tamara Burdon RN-BC, CCM
Program Manager, Care Management Department
Community Care Partners of Greater Mecklenburg

Jennifer Cockerham, RN, BSN, CDE
Senior Vice President of Clinical Programs
Community Care of North Carolina

Evelyn Clemmons, RN, BSN
Director of Quality Improvement
Southern Regional AHEC

Atha Cutler, MPH
Program Evaluation Assistant
NC Community Care Networks, Inc.

Samuel Cykert, MD
Associate Director, Medical Education, and Clinical Director,
NC Regional Extension Center
NC Area Health Education Centers Program
UNC Chapel Hill

Christine DeLong Jones, MD, MS
Assistant Professor of Medicine
Director of Care Transitions for the Hospital Medicine Group
University of Colorado, Denver

L. Allen Dobson, Jr., MD, FAAFP
Vice President Clinical Practice Development
  Carolinas HealthCare System
President, North Carolina Community Care Network, Inc.

C. Annette DuBard, MD, MPH
Senior Vice President of Informatics and Evaluation
Community Care of North Carolina

Vicky Epps
Deputy Director
Access Care

Brian Erman, MSPh
Data Analyst
Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill

Tammy Godusi, RN, BSN, CCM
Community Care of Wake and Johnston Counties

David Hainline, MA, MS, RHIA
Director, HIT, REC and Quality
Charlotte AHEC

Fran Harris, RN, CCM
Pediatric Quality Improvement Coordinator
Community Care of Lower Cape Fear

Carlos Jackson, PhD
Assistant Director of Program Evaluation
NC Community Care Networks, Inc.

Michael Lancaster, MD
Director, Behavioral Health Program
North Carolina Community Care, Inc.

Libby Lawson, RN, MEd
Quality Improvement Coordinator
Community Care of the Lower Cape Fear

Ann Lefebvre, MSW, CPHQ
Associate Director, Statewide Quality Improvement
NC Area Health Education Centers Program
Executive Director, NC Regional Extension Center

Denise Levis Hewson, RN, BSN, MSPH
Former Director of Clinical Services and Quality Improvement
NC Community Care Networks, Inc.

Beth Lopez, RN
Program Manager
Community Care Partners of Greater Mecklenburg

Carlee McConnell
Former Research Assistant
NC Area Health Education Centers Program

Tammie McLean RN, BSN, CCM
Network Director
Community Care of the Sandhills

Marci Miles
Network Director
Access Care

Cindy Oakes, BSN, RN
Former Executive Director
Community Care of Southern Piedmont

Tara Robinson, RN, BSN, CCM
Deputy Director/Privacy Officer
Community Care of Wake and Johnston Counties

Robin Roche, MSW, LCSWA
AccessCare of Central Carolina
Embedded Care Manager at UNC Internal Medicine Clinic

Jill Smith, RN, BSN
Former Director, Center for Quality Improvement
Greensboro AHEC

Lynne Taylor, RN, BSN, CPHQ
CHIPRA QI Facilitator
Community Care of North Carolina

Cathy Webb, BSN, RN
Education Specialist, REC and Quality Grants
Charlotte AHEC

Mary R. Webster, MSN, RN, CCM, AE-C
Director CME, Pharmacy, REC & Quality Grants
Charlotte AHEC/Regional Education
NC Regional Extension Center

Sandi West
AccessCare

Neil Williams, Pharm D, CPP
Clinical Pharmacist Coordinator
Community Care of North Carolina
Vice President Clinical Services
Medication Management, LLC

Executive Summary

From April 2012 to September 2013, nine North Carolina primary care practices participated in a care transitions learning collaborative. Each practice agreed to pilot test and further develop a care transitions change package based on the IHI STAAR Initiative's *How-to Guide: Improving Transitions from the Hospital to Post-Acute Care Settings to Reduce Avoidable Rehospitalizations*.[1] The practices learned and tested processes that would help them make key changes prior to the visit, during the visit, and at the end of the visit.

The **key driver diagram** (see Figure 2 on the next page) outlines the progression of steps a practice should take toward creating successful patient transitions from hospital to practice. There are a variety of possible changes practices can make to reach the goals on the diagram. Using the **Model for Improvement**[3] (Figure 1), practices are encouraged to select and test changes to determine if they result in improvement. If you are not familiar with these strategies, you can learn more by visiting the Institute for Health Improvement website (IHI.org) and clicking on "Knowledge Center".

Fig. 1 Model for Improvement[3]
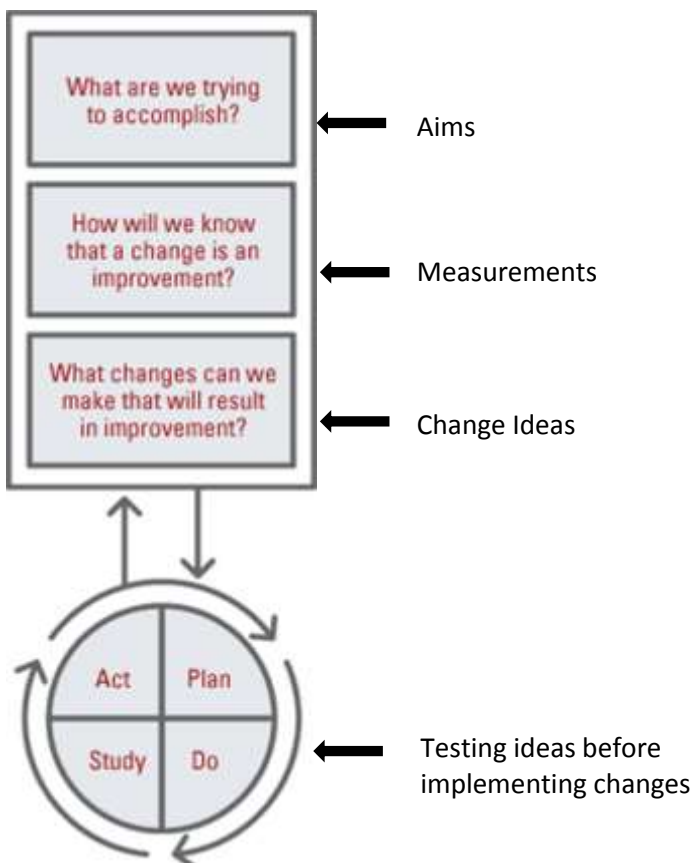
Aims

Measurements

Change Ideas

Testing ideas before implementing changes

The idea is to start small, assess, adjust, and gradually tweak or build new processes that allow your practice to fulfill the primary drivers of the key driver diagram.   Much of the success or failure will have to do with appropriately assigning roles and responsibilities within the practice. Who will be responsible for identifying the patients who are being discharged, obtaining the discharge summaries, reviewing the discharge summary, etc.? One of the first steps is to assess your practice processes for care transitions, and then review this template to assign roles and responsibilities in your clinic.

Care Transitions Key Driver Diagram for Practice Setting

Aim	Primary Drivers	Secondary Drivers	Changes/Future PDSAs
Aim: Decrease avoidable readmissions and emergency department visits by improving outpatient care transitions process	**Provide Timely Access to Care**	Review admissions & discharges info daily	
		Provide the appropriate level of care for discharged patients	
	Plan Post-Discharge Visits	Clinical team reviews discharge summary prior to patient visit	
		Provide the appropriate level of care for discharged patients	
		Coordinate care with home health nurse, care manger, pharmacists, etc.	
		Follow post-discharge checklist	
		Ensure med reconciliation	
	Assess Patient & Create/Update Care Plan	Ensure all needed follow-up was completed	
		Use teach-back method to instruct patient on: 1) self-management, 2) warming signs and proper response, and 3) how to access the practice	
		Provide reconciled, dated medication list to patient, family, care manager, home health nurse, etc.	
	Communicate the care plan	Communicate the care plan to patient, family, care manager, home health nurse, etc.	
		Schedule the next appointment	

Introduction

Why Address Care Transitions?

In the United States, we spend an estimated $10.1 billion each year on potentially preventable 30-day readmissions.[1] Besides being an enormous and unnecessary expense, preventable hospital readmissions are harmful to patients' health, resources, and family well-being. Experts believe that 76% of 30-day readmissions could be prevented.[2] Improving care transitions is one way to prevent them.

Successful care transitions from hospital to primary care can help patients avoid serious complications. Recently discharged patients may be tired, worried, distracted, or cognitively impaired—all of which make it harder to learn and retain information. To make sure patients are stable, taking appropriate medicines, understand their home care instructions, and have access to needed services, patients need immediate access to their primary care provider. Most primary care practices can benefit from instruction on how to implement processes to efficiently and effectively provide these services on short notice.

NC IMPACT Care Transitions Learning Collaborative

Keeping patients – especially those with complex, chronic disease, low literacy, meager financial resources and minimal or no social support – out of the hospital and promoting healing, recovery, and good quality of life depends on ongoing improvement of multiple dimensions of the US health care system, as well as coordination and collaboration between health care and community resources. It's a particularly challenging proposition because we lack effective systems to facilitate information management, processing and sharing, which are critical. Also, we do not reliably plan, anticipate and prepare for patients' needs (for a variety of cultural, professional, and historical reasons). Despite the complexity of the problem, the overwhelming prospect of fixing it and the fact that primary care is but one part of the cause and solution, we can do something.

Creating a Primary Care Change Package
From April 2012 to September 2013, nine North Carolina primary care practices participated in a Care Transitions Learning Collaborative. Each practice agreed to pilot test and further develop a care transitions change package based on the *Institute for Healthcare Improvement* (*IHI) How-to Guide: Improving Transitions from the Hospital to Post-Acute Care Settings to Reduce Avoidable Rehospitalizations*,[1] The practices learned and tested processes that would help them make key changes prior to the visit, during the visit, and at the end of the visit. This Collaborative's curriculum was intended to promote a structure and planned approach for learning how to improve care transitions processes in primary care. It focused on 4 key areas of change:
    (1) provide timely access to care following a hospitalization,
    (2) prepare for post-discharge visits,
    (3) conduct a thorough post-discharge visit; and
    (4) communicate and coordinate an ongoing care plan.

The **key driver diagram** (see Figure 2 on the page 12) outlines the progression of steps a practice should take toward creating successful patient transitions from hospital to practice. There are a variety of possible changes practices can make to reach the goals on the diagram. Using the **Model for Improvement**[3] (see figure 1), practices were encouraged to select and test changes to determine if they resulted in improvement. If you are not familiar with these improvement strategies, you can learn more by visiting the Institute for Health Improvement website (IHI.org) and clicking on "Knowledge Center".

Real-time technical support (coaching) for the collaborating practices was provided by the NC IMPaCT faculty, NC AHEC, and CCNC. Practices were encouraged to participate in monthly instructive and sharing webinars and received individual coaching. Coaching was a helpful resource, especially for smaller practices. Coaches provided guidance, focus, and administrative hands that helped the practice maintain momentum amidst already hectic schedules. Even with technical support, practices faced a number of common challenges implementing the change package. These challenges included: engaging a practice champion, practice disruptions, difficulty obtaining admission and discharge information from hospitals, patient psycho-social issues, linking patients with community resources, and collecting data. We learned that practices should expect disruptions to be the norm and be prepared to make necessary adjustments that enable them to continue in spite of inevitable barriers. Each practice formed a team, identified opportunities for change, developed an aim statement, collected baseline data, established measures, selected changes, tested changes, and implemented changes.

Fig. 1 Model for Improvement[3]

Aims

Measurements

Change Ideas

Testing ideas before implementing changes

Short-Term Results
Most of the practices made substantial changes. They made connections with hospitals, improving communication about admitted and discharged patients and more timely exchange of the discharge summaries. Practices improved their processes for planning follow-up visits, made plans for after-hour access, and educated their patients about after-hours access. Several practices implemented and improved their medication reconciliation efficiency.

All of the practices generated ideas for how to implement process changes in their practice. AHEC and CCNC QI coaches also gained experience facilitating these changes in primary care practices.

Expected Results
The length of our Collaborative was not long enough to show trends in our outcome measures. However, we believe if practices sustain the improvements they have made, they will see:
- Reduced percent of discharges with readmission for any cause within 30 days
- Improved patient outcomes and satisfaction
- Practices will have improved access to timely care following a hospitalization
- Patients and clinical team will be better prepared for patient visit

Figure 2. Care Transitions Key Driver Diagram for Practice Setting

Aim	Primary Drivers	Secondary Drivers	Changes/Future PDSAs
Aim: Decrease avoidable readmissions and emergency department visits by improving outpatient care transitions process	**Provide Timely Access to Care**	Review admissions & discharges info daily	
		Provide the appropriate level of care for discharged patients	
	Plan Post-Discharge Visits	Clinical team reviews discharge summary prior to patient visit	
		Provide the appropriate level of care for discharged patients	
		Coordinate care with home health nurse, care manger, pharmacists, etc.	
		Follow post-discharge checklist	
		Ensure med reconciliation	
	Assess Patient & Create/Update Care Plan	Ensure all needed follow-up was completed	
		Use teach-back method to instruct patient on: 1) self-management, 2) warming signs and proper response, and 3) how to access the practice	
		Provide reconciled, dated medication list to patient, family, care manager, home health nurse, etc.	
	Communicate the care plan	Communicate the care plan to patient, family, care manager, home health nurse, etc.	
		Schedule the next appointment	

How to Use this Change Package

Much of the care transitions improvement work that's been done in the past few years is hospital based. This change package focuses on the changes that need to occur within the primary care practice in order to reduce readmissions and improve care transitions. It is designed to help practices and coaches implement process changes that lead to measurable improvements for care transitions. Using the **Model for Improvement**[3] (Figure 1) and the key driver diagram, practices are encouraged to select and test changes to determine if they result in improvement. If you are not familiar with these strategies, you can learn more by visiting the Institute for Health Improvement website (IHI.org) and clicking on "Knowledge Center".

The idea is to start small, assess, adjust, and gradually tweak or build new processes that allow your practice to fulfill the primary drivers of the key driver diagram.   Much of the success or failure you experience will have to do with appropriately assigning roles and responsibilities within the practice. Who will be responsible for: identifying the patients who are being discharged, obtaining the discharge summaries, reviewing the discharge summary, etc.? After you assess your practice processes, review this template to assign roles and responsibilities in your clinic.

Who should use this change package?
1. This change package is intended to help those who need:
   a. Quick reference to methods and tools that would help them re-think practice design and implement low-risk, incremental strategies that build toward sustainable change.
   b. Tools and methods that would help integrate care transitions work with other Patient-Centered Medical Home (PCMH) requirements they are trying to meet.
2. How to use this tool box:
   a. This change package is made up of a progression of step-by-step exercises that will help you begin organizing a care transitions program in your practice.
   b. This change package can be read cover to cover as an introductory text on the steps toward creating successful transition from hospital to practice, or can be used in segments for specialized content in a specific area. Through the tools and links provided in the document, it also can serve as a jumping-off point for accessing other resources on care transitions.

1 | Getting Started

Getting started can be simple. Start by reviewing a few recent readmission cases, consider what could be done differently, and determine your practice's hospital readmission rate. Follow the steps in the adjacent box, and use the links provided for more detailed information if you need it.

STEPS

Step 1. **Identify opportunities for improvement.**

1. **Review cases -** Review the last 5 hospital readmission cases, and analyze them to see if anything could have been done to prevent the readmission.

   For example:
   - Did the patient have a timely follow-up visit?
   - Did any med rec take place?
   - Was the practice informed about the patients' hospitalization?

2. **Assess practice processes** - Use the *Care Transitions Processes Assessment Tool* to help assess your practice's processes. Appendix 1, page 32.

Note: Not all readmissions are preventable or amenable to system changes (e.g., some may be planned readmissions. Some may have medical problems that may not be preventable).

Step 2. **Gather baseline data for your practice.**

1. Do you know when your patients are discharged?
2. Is the discharge summary available before the follow-up visit?
3. How many readmissions or visits to the emergency department have there been within 30 days.

Step 3. **Develop an aim statement & charter for your work.**

You should define what you want to achieve by implementing care transitions changes in your practice. The aims should be time-specific, realistic, and measureable.
1. What to improve
2. Where
3. By when
4. A measureable goal

For example, an aim to promote medication adherence may be: "Over the next 6 months, the practice will put systems in place to remind all patients to bring medicines to every visit."

More Example Aim Statements

A. Implementing a PDSA

Like the Institute for Healthcare Improvement (IHI), we used the Model for Improvement[3] as the framework to guide improvement work. Based on current knowledge and the plan-do-study-act (PDSA) cycle for learning and improvement, the Model for Improvement is a tool for accelerating improvement. To use the Model, you must first decide what you are trying to accomplish (your aim statement). Then consider how you will know if change is an improvement, and what changes will lead to an improvement. Then use the PDSA cycle to test changes on a small scale. By repeating the PDSA cycle you will be able to learn more about your process and whether the change is effective.

After you have developed your aim statement, you are ready to test your first change. Use the PDSA worksheet to implement a PDSA. We encourage you to take risks and not to worry about failures because your team will learn from them.

STEPS

Step 1. Identify a change that is needed.

Examples of processes that can be measured on a small scale
- Do your patients know how to access your practice after-hours?
- Do you know when your patients are discharged?
- Do you schedule follow-up visits for recently discharged patients within 5 days or less?
- Do you have discharge summary before the visit?
- Can your patients teach back warning signs and medications?
- Is the medication list reconciled?

Step 2. Collect baseline data.
For example:
1. How many readmissions does the practice have each month?
2. How many post-discharge follow-up visits does the practice have each month?

Step 3. Test the change with 5 patients
See sample PDSAs starting on page 48

Step 4. Collect data on the change.

Step 5. Compare the new data to the baseline data.
If it appears to be working, consider enlarging the test to include more patients. If it is not working, why? What can you change to re-address the issue?

B. Patient Risk Stratification

The identification of a patient's health risk category is the first step toward the patient's care plan. For the purposes of care transitions, identifying high-risk patients will help you determine who needs increased support from your practice.

This section provides advice on how to develop an approach for stratifying the risk of all patients (all payers, uninsured, self-pay, etc.) about to be or recently discharged from the hospital. Patient risk for readmission can be influenced by age, level of independence, health, socio-economic status, geographic location, etc. The table below provides some potential risk stratification categories. The American Academy of Family Physicians Risk-Stratified Care Management and Coordination chart is also a helpful resource (see Appendix 1).

See case study 4 on page 98

STEPS
Step 1. Select a risk stratification approach. See examples in table below.
Step 2. Prototype & test a risk-stratification approach.   1. Evaluate what percent of your patients are categorized as high or moderate risk (likely ¼ to ½ will be high/moderate risk).   2. Understand special cases when someone categorized as low risk is really higher risk.   Examples of PDSAs are in Appendix 2.   See Appendix 1 for The American Academy of Family Physicians Risk-Stratified Care Management and Coordination chart.

Potential risk stratification characteristics you could use
Patient has 1 or more inpatient admissions (included acute, mental health, and long-term care admissions) other than the index admission
Patient has 3 or more ED visits or 3 or more outpatient providers within the past 6 months
Patient is Dual Eligible (Medicare + Medicaid) and meets all 3 of the following criteria: 1 or more key target conditions (Congestive Heart Failure, Diabetes, Ischemic Vascular Disease, Asthma or Chronic Obstructive Pulmonary Disease), 1 or more inpatient admission, and 2 or more ED visits within the past 6 months
Patient has 6 or more chronic conditions
Patient has 10 or more medications (Alternate: More than 11 prescriptions in the past 1 month or 33 prescription in the past 3 months)
Patient's ability to perform independent activities of daily living

2 | Providing Timely Access to Care Following Hospitalization

A. Getting Patient Information from the Hospital

The risk of re-hospitalization is high in the first few days after discharge, which means patients should be seen within days, not weeks.[4] We recommend high-risk, post-discharge patients be seen in the clinic for follow-up within five days of discharge. To do this, practices must have hospital admission/discharge information and the capacity to schedule appropriate follow-up visits on short notice.

Unfortunately, many practices do not know when their patients are in the hospital, and many will not have a discharge summary in this short amount of time. In fact, one study found that only 3%-20% of hospitals communicate with the patient's primary care provider.[5]

This section provides of steps your practice can use to create processes to obtain needed patient information from the hospital.

STEPS
Step 1. **Obtaining data from the hospital: Identify patients who are admitted.** Develop a relationship with at least one of your hospitals to establish a method for obtaining patient admission and discharge information. Examples of PDSAs are in Appendix 2.
Step 2. **Test the process for a couple weeks. Is the hospital notifying you for every discharged patient?** Understand what is working and not working and plan to meet again with the hospital until you get 100% notification of patients getting discharged.
Step 3. **Develop a process in your practice to use this information to begin assisting your patient's transition.** This could include a call to check on the patient and scheduling a visit for the patient to come in for evaluation.

B. Paying for a More Complex Visit: Medicare Visit Codes for Transitional Care Management

The post-discharge visit is more complex than other office visits, and thus is more costly. Medicare has new visit codes for transitional care management. For the visit to be eligible, the practice must have phone contact with patient within 2 business days of discharge.[6]

Visit	Code	RVU	Reimbursement
Face-to-face visit within 7 days	99496	6.79	~$230
Face-to-face visit within 14 days	99495	4.82	~$163

C. Expanding Access to Care: Developing Capacity to Schedule Follow-up Visits

The section will help you develop the capacity to schedule follow-up visits on short notice.

A resource for specific strategies on how to expand access is the *Safety Net Medical Home Initiative: Enhanced Access: Providing the Care Patients Need, When They Need It.*[7] We also included examples of the PDSAs and case studies implemented by the practices in our collaborative.

See case study 2 and 3 on pages 96 and 97

STEPS
Step 1. **Risk Stratify Your Patient Population.** (see page 16)   Examples of PDSAs are in Appendix 2.
Step 2. **Develop a process to increase access to care for patients** referred by the ED or inpatient discharges and those calling in with acute complaints.   1) Add same day access. See Enhanced Access: Providing the Care Patients Need, When They Need It (page 18)[7]   Examples of PDSAs are in Appendix 2.
Step 3. **Survey 5 patients to see if they are aware of your practice's after-hours access and how to access it.**   Examples of PDSAs are in Appendix 2.

3 | High-Risk Populations

What Happens after the First Post-discharge Visit?

Providing enhanced access to your high-risk patients will help reduce readmissions and emergency department visits.[8,9] This section provides advice on expanding access to high-risk patients. Follow these steps to identify your high-risk patients, test ways to increase the frequency of contact with your high-risk patients, develop and test ways high-risk patients have access to the practice.

Once high-risk patients are identified, strive for more frequent interactions with these patients to monitor health status and set expectations for ongoing management. Given the complex care plans for these patients, more frequent interactions can offer proactive support to patients managing their conditions—and identify when the care plan requires adjustment.

STEPS

Step 1. **Identify your high-risk patients** (see page 16).

Step 2. **Increase frequency of patient communication.**
For example, some practices assign a nurse to call patients once a month. Calls can focus on a range of topics from basic disease management to motivating behavior change. For other ideas and techniques, the Safety Net Medical Home Initiative: Enhanced Access: Providing the Care Patients Need, When They Need It[7] is a helpful resource.

Step 3. **Remove barriers high-risk patients may face trying to access the practice.**

Test how your phone tree works during the day and after-hours.
Patients may try to call in, but get lost in the phone tree and opt for an emergency room visit instead. Your high-risk patients should be able to reach someone in the office easily and without delay. Can your practice provide a "hot line" for the high-risk patient?

Step 5. **Provide after-hours contact information to patients.**
Patients may not be aware the practice has after-hours access.

Step 4. **Develop and test a system of enhanced access for your high-risk patients.**
For example, some nurses carry a cell phone that high-risk patients and families have direct access to. For more information on how to expand access see: the Safety Net Medical Home Initiative: Enhanced Access: Providing the Care Patients Need, When They Need It.[7]

4 | Preparing for the Post-Discharge Visit

A. Preparing the Patient and Clinical Team

There are a number of steps you can take before the patient arrives for the follow-up visit that will help ensure the visit is comprehensive and efficient. The steps listed here will help you anticipate the needs of the patient and consider issues that may require a change in the patient's treatment plan.

You may run into some barriers as you try to make these changes. Not having a discharge summary is fairly common. If you do not have the discharge summary, consider calling the discharging physician to get a report. For the long run, you will need to develop a more routine way to communicate with the hospital about discharged patients. Other common challenges include:

Common Challenges and Possible Solutions
C: No discharge summary or medication list
S: *Discuss discharge summary policy with hospital, explain your needs*
C: Difficulty clarifying information with hospital physician
S: *Arrange meeting with hospital physicians to agree on strategy*
C: Practice may not be aware of patient's barriers to keeping the appointment
S: *Talk to your patient. Ask about their plans, ask what barriers they have*
C: No contact with care managers/home health
S: *Create a communication plan with home health agency*
C: Patients don't understand importance of this visit
S: *Reinforce importance on phone call. Ask hospital team to reinforce*
C: Patients don't really understand who to call or what to do if they get sick.
S: *Create flier with easy instructions on what to do*

STEPS
Step 1. **Review the discharge summary**.   1. Identify any questions for discharge team.   2. Identify any medications that need stopping, starting, or adjusting (e.g., Lasix).   3. Identify tests that need follow-up.   4. Identify any urgent issues need addressing immediately.   5. Identify key patient education needed at visit.
Step 2. **Clarify outstanding questions with discharging physician.**   1. Identify the best way to do this (through EHR, email, phone).   2. Clarify what is needed in discharge summary.

Step 3. **Place reminder/preparation call to patient/family.**
 1. Do this in first 48 hours after discharge.
 2. Have a script that emphasizes:
   a. Importance of follow-up visit, identify barriers (ask patient how they plan to get to the office)
   b. Bring all medications to the visit
   c. Bring discharge paperwork
 3. Make sure patient knows who to contact in case of emergency or with questions.
 4. Make sure practice phone tree is simple, and patients can reach who they need when they call.

Step 4. **Coordinate care with home health/care managers as needed.**   1. Encourage care managers and home health to send a note to the visit with the patient or to contact your office prior to the visit.   2. Identify the biggest concerns for patients' short- and long-term success.

B. Testing a Post-discharge Visit Protocol

This section will help your practice prepare for and develop a post-discharge visit protocol. During the post-discharge plan you should asses the patient's current condition, perform a medication reconciliation, review the patient's treatment plan, and make sure the patient and family members understand their care plan.

This section includes steps that will help you test your post-discharge protocol, designate staff roles, test telephone access to the practice, and adopt a post-discharge checklist. Follow the steps in the yellow table to develop and test your protocol.

STEPS

Step 1. Test a post-discharge visit protocol with at least 3-5 patients.
1.   At least one patient should be a high-risk, non-Medicaid patient.
2.   Protocol should delineate post-discharge roles and responsibilities of practice clinicians, staff and care managers (see Step 2).
3.   Use or create a checklist for your protocol (see Step 4).

During the Visit
1.   Work with the patient to help them set individualized goals related to their recent hospital stay and prevention of readmission.
2.   Assess patient's perception and understanding of what led to the recent hospital stay.
3.   Reconcile medications and use teach back or similar techniques to facilitate patient understanding of their medication plan.

Step 2. Clearly assign roles and responsibilities.
Use this template to assign roles and responsibilities in your clinic. Who will be responsible for: identifying the patients who are being discharged, obtaining the discharge summaries, reviewing the discharge summary, etc.?

Step 3. Adopt a checklist or template (e.g., one that you create or generated from your EHR template).

Appendix 3 includes the following checklists:
1.   Nurse/MA Checklist for Post-Hospital Follow-Up Visits
2.   Provider Checklist for Post-Hospital Follow-Up Visits
3.   COPD Checklist: Goals and Recommendations
4.   Heart Failure Checklist: Goals and Recommendations
5.   MI Checklist: Goals and Recommendations

5 | Assess Patient and Create Care Plan
A. Medication Reconciliation

Fifty percent of all hospital-related medication errors (and 20% of all adverse drug events) are attributed to poor communication during transitions of care.[10] Medication reconciliation and patient counseling reduces the chance of readmission.[11]

Medication reconciliation is the process of identifying duplications and/or discrepancies between the medication lists and other sources (e.g., fill history, patient interview, primary care provider chart) arising from uncoordinated care or patient non-adherence.

Medication List Sources
There are many sources for medication lists, but finding a single accurate list is unlikely. When comparing the admission list to the primary care provider's medication list, you are likely to find several medications omitted. CCNC's Provider Portal provides a list based on Medicaid claims data. The patient report is also important, but probably incomplete. <u>The best source of what the patient is actually taking is having the patient bring all bottles to the clinic.</u>

When to do the medication reconciliation?
Medication reconciliation is difficult to do during the hectic daily routine. If this is a transitional program, consider doing as much of the medication reconciliation as you can <u>before</u> the office visit. Utilize CCNC staff if the patient is enrolled with CCNC. Take advantage of the clinical pharmacists if you have them. Use other office staff if possible. In some practices with a clinical pharmacist, the nurse will check in the patient, get vitals and escort the patient to an exam room. The pharmacist will conduct medication reconciliation and/or review prior to physician visit.

See case studies 5 and 6 on page 99 and 100.

STEPS
Step 1. Perform a small scale assessment of how many patients brought medications to follow-up appointment, of these, how many got a medication reconciliation?
Step 2. Track how often patients are reminded to bring medications to their follow-up appointment.
Step 3. Establish roles of who will perform the medication reconciliation.
Step 4. Remind the patient to bring all of their medications (even over-the-counter meds) to the office visit.
Step 5. Compile a set of medication lists by source, including but not limited to: • Discharge instructions from hospital/facility if applicable • PCP Chart/EMR • Fill History [Pharmacy Home/ Case Management Information System (CMIS)] • Patient Report • Specialist(s) Chart(s)/EMR(s) • Home care-based service provider • Retail Pharmacy
Step 6. Reconcile the various lists.
Step 7. If there appear to be complex issues, then refer to a pharmacist partner or the primary care provider.

> Note: Sometimes regular medications are stopped during a hospital stay, but later need to be restarted, so out-patient medications need to be reconciled too. For example, furosemide for congestive heart failure may be stopped in hospital because of dehydration from a vomiting illness, but will need to be restarted when dehydration resolves.

Who should be involved in the medication reconciliation?
Medication reconciliation is a collaborative effort. It should involve:
- CCNC transitional care program (Care management staff, Clinical pharmacist staff)
- Hospital transitional care program staff (Hospital pharmacist staff, Discharge planning staff)
- Home health medication reconciliation
- Embedded clinical pharmacists
- Community pharmacy partners
- Specialists
- Primary care practice

Common Problems
- Discontinued medication per discharge instructions, but the patient is still taking
- Not taking prescribed discharge medication
- Poor adherence to chronic medication
- Medication dose/frequency/duration discrepancies
- Potential transcription error, combo drug, miss-naming
- Absolute contraindication
- Interaction non-absolute
- Adverse event/side effect reported
- Two medications from the same class
- Drug allergy
- Unconfirmed discontinuation

When Talking with the Patient

1. Ask open ended questions.
2. Try to fill in missing elements (drug strength, directions).
3. Hold up medicine bottle and ask "How are you taking this? What are you taking it for?"
4. If patient is taking medicine in a manner not prescribed ask "Why are you taking it that way? Who instructed you to do that?"
5. If patient does not have medicine ask, "Where is the medicine?"
6. Look for opportunities for education or reinforcement.
7. Constantly reinforce bringing medications to the office visit.

B. Integrating Care Managers & Care Coordination

Managing complex patients can be challenging for practices. Patients with multiple chronic conditions fill more prescriptions, see more doctors, and are at greater risk for medical errors and readmissions. Providing care coordination can help de-fragment care, manage high-risk/high-cost patients with multiple co-morbidities, and, in turn, improve quality.

In our state, Community Care of North Carolina supports network practices with care managers who coordinate care for Medicaid patients. They are primarily responsible for helping to identify patients with high-risk conditions or needs, assisting the providers in disease management education and/or follow-up, helping patients coordinate their care or access needed services, and collecting data on process and outcome measures. Other payer organizations occasionally provide care management. Some practices develop their own care management system. Lastly, home health agencies can provide some of this service for patients who qualify. If CCNC is not available, try to develop real-time connections with home health agencies.

> ### STEPS
>
> **Step 1. Integrate the care manager into post-discharge visit care plan.**
>
> 1) What care management resources are available in your practice? How can you use care management optimally?
> 2) The care manager can visit patients at home in the days immediately after discharge.
> 3) The care manager should communicate with provider team about the key challenges for the patient before the primary care visit and continue care after the primary care visit.

Care management and coordination helps ensure high-risk patients have:
- Drug therapy and medication management that gets them safely to therapeutic goals.
- Effective self-management support so that they can manage their illness competently.
- Evidence-based monitoring and self-monitoring to detect exacerbations and complications early.
- Follow-up tailored to severity, and more intensive management for those at high risk.
- Timely, well-coordinated services from medical specialists and other community resources.
- Safe, balanced therapeutic goals and integrated care plan.
- Preventive interventions at recommended times.

C. Connecting Patients with Community Resources
(adapted from the Health Literacy Tool Kit –Tool 18 Link Patient's to Non-medical Support) [12]

In primary care, we sometimes assume we don't have time to help patients with non-medical issues like understanding health care benefits, accessing medication, or dealing with housing and transportation issues. This assistance, however, is critical to achieving optimal health. It is not a matter of merely having a list of support services and making referrals. Often we make a referral, but the connection is never made. Practices need to anticipate these problems and make a commitment to ensure patients connect with needed services in a timely manner. Making sure this happens involves assigning responsibility for support activities, allocating staff time, and tracking outcomes.

This section will help you develop approaches to assess patients' needs for additional services, provide ideas for developing a list of community services, and ultimately create a system for helping patients with non-medical needs. Follow the steps on this page and think creatively about who you can involve in your practice and how you might implement this over time.

Practices should have and use a current list of community resources. See the next page for steps on how to create, maintain, and use the list.

STEPS
Step 1. Test with 5 patients.   <u>Assess the problem.</u> Take time to listen to patients about the other things that may inadvertently be affecting their health, and take some ownership at trying to help them overcome these challenges. Keep track of these issues in the chart.   <u>Involve current support systems.</u> Most patients will have a support system in place, either formal or informal. Asking patients how they get certain needs met may reveal that they have a case manager or local social service agency that helps them. They may mention a friend or family member that provides support. This support system may be very helpful at assisting the patient with achieving medical goals, but you may also want to make a direct connection. Ask the patient if you can invite them to clinic appointments, e-mail them, or call them.
Step 2. Make referrals.
Step 3. Check the 5 patients' charts 1 month later to see if the outcome of the referral is documented.

D. Developing and Implementing Use of a Community Resources List

(adapted from the Health Literacy Tool Kit –Tool 18 Link Patient's to Non-medical Support) [12]

Common Resources Patients May Need
- Food pantries and goodwill locations
- Transportation services
- Domestic violence shelters
- Youth mentoring programs
- Budget management programs
- Teen pregnancy programs
- Support groups
- Services for the hearing or visually impaired
- Aging and caregiver services
- Employment assistance program
- Department of Social Services

STEPS

Step 1. Develop a community resources list.
There are many ways to identify and obtain contact information for agencies and non-profits in your community. The United Way and AIRS (Alliance of Information and Referral Systems) 2-1-1– Information & Referral Search can usually provide you with a phone number to call for information about the social services in your area, or you can dial 2-1-1 on your phone. You can also contact your local Chamber of Commerce, or city or county government agencies for a list of services and programs in the area. Ask these agencies to send pamphlets or to give a presentation to your practice so you understand their services, referral process, and know a contact person.

Step 2. Assign someone to maintain the community resources list.
Have one person in your practice gather information and document the referral process. Make sure it is updated regularly. Train everyone on how to use the resource guide, or centralize the process and have one person do the referrals.

Step 3. Track your progress.
1. Test whether your resource book is up to date. Call four randomly chosen service providers, and verify their information.
2. Conduct a spot check of your charts. Choose 10 charts at random, and see if they record patients' non-medical challenges, the patient's support systems, and how the practice interfaces with them. Repeat again in 3 months, and see if charts are more complete.
3. Track how many referrals are made in a month and then again after a few months of implementation.

6 | Communicating the Care Plan—the "Teach Back" Method

According to the Health Literacy Universal Precautions Toolkit, "40-80 percent of the medical information patients receive is forgotten immediately and nearly half of the information retained is incorrect."[12] Using the "teach-back" method is one of the easiest ways to make sure you know you have communicated clearly with the patient. With this method, the patient confirms their understanding by explaining it back to you.[12]

Follow the steps in the adjacent table to begin implementing the "teach back" method in your practice. We recommend you use the provided links for additional information—especially "How to Implement 'teach back' method".

How to ask your patients to teach back
This technique creates the opportunity for dialogue in which the physician provides information, and then encourages the patient to respond and confirm understanding before adding any new information. Ask the patient to explain or demonstrate understanding in a way that is not demeaning. Ask patients to demonstrate understanding, *using their own words*. It is important not to appear rushed, annoyed, or bored during these efforts – your affect must agree with your words. Remember to use a caring tone of voice and attitude. Use plain language. Ask patient to explain using their own words (*not* with "yes/no" answers).

For more instruction on communicating with patients, please visit: The Health Literacy Universal Precautions Toolkit.

STEPS
Step 1. Implement a PDSA to practice using teach back method with 5 patients.   Remember to limit the number of teaching points. Teach-back is most effective with 1-3 points.
Step 2. Engage others to assist the patient (family, home health, follow up doctors).   For the 5 patients above, try to reach out to others who can support the patient with their care plan.
Step 3. Provide the patient with written instructions for their care plan.   • Remember there is cognitive decline during hospitalization. No matter how good your patient's education is, it will be hard for one person to remember all of the information. Make sure the written follow-up plan is in place to reinforce with the patient, primary care practice, home health, and family members.   • Use materials patients' understand. For additional information see: design easy-to-read material.
Step 4. Track your progress using teach back.   The Teach-Back Self-Evaluation and Tracking Log provides a method for staff to document their experience using the teach-back method. Encourage staff to use the logs, and hold a discussion about their experience. This will allow people to share teach-back strategies that worked best. In addition, it is helpful to ask patients if they find the teach-back interaction positive and helpful during the patient encounter.
Step 5   **Assess how often the teach-back is used.**   A few weeks after first trying the teach-back, track how many clinicians or staff members are using it. Have each individual keep a log of when and how it was used over the course of a few days.

Examples of how you might begin the "teach back" conversation with patients.
- "What will you tell your spouse about your condition?" Find a way that takes pressure off the patient.
- "I want to make sure I explained everything clearly, please tell me in your own words what you heard me say so I can be sure I did"
- "I want to be sure I explained everything clearly. Can you please explain it back to me so I can be sure I did?"
- "What will you tell your husband about the changes we made to your blood pressure medicines today?

7 | How Do We Know that Change Is an Improvement?

Measures Part 1: Begin Tracking

Measures are used to determine if a change is an improvement. There is no standardized list of measures for primary care. We reviewed the *IHI How-to-Guide's* suggested measures along with some others, before finally narrowing our focus to four key measures.

1) 30-day all-cause readmission
2) Discharge summary at first appointment
3) High and Moderate Risk Patients Seen within 5 Days of Discharge
4) Timely Hospital Discharge Notification

We will talk more about these measures in Part 2, but for this section, you want to develop a baseline picture of what is happening in your practice. Determine what data you have access to, what you can collect, and how you are going to track it. Getting perfect data is difficult. As you begin, ask these questions:

1) Can we get data that helps improvement?
2) Are there places we can start even if we don't have all the data?

STEPS
Step 1. **Create a dashboard of measures you plan to track.** See sample dashboard table below. You can customize this for your practice.
Step 2. **Track 30-day all-cause readmissions (number and percent) for your practice.**   Strategies for how to do this: ➔ Keep a list of all discharged patients that come in for follow-up visits.   ➔ Use CCNC data on readmissions (Medicaid only). You may have very small numbers due to only having part of the patient population.   ➔ Get a list(s) from your hospital(s).
Step 3. **Document the number of follow-up visits you have each week.**

Following the steps in the yellow table will help you determine how many of your patients are being readmitted and how many are returning for follow-up appointments, in addition to setting you up to track processes in your practice.

Sample dashboard table (Step 1)

Patient Name	Discharge Date	Follow-up appointment date	Discharge summary obtained	Teach back warning signs and medications	Medication reconciliation performed	
Jane Smith	1/1/2013	1/5/2013	1/4/2013	Yes	yes	

Measures Part 2: Process and Outcome Measures

Now that you have an idea of how many readmissions your practice has each month, what data source you will be using, and how you will record it, you can consider other measures. This section will help you assess whether your measures are actually measuring what you are trying to improve and develop a more comprehensive tracking system.

Don't get discouraged if you can't find the data you want. Lack of available data is a key problem for measurement and care. Some measures will be easier to collect than others, and some measures may need to change. If a measure does not work for your practice, we encourage you to customize it or change it until it works.

We use two main categories of measures: process and outcome.

Process Measures	Outcome Measures
✦ Process measures can be tracked in short time frames and with small samples. ✦ How the system works. ✦ Process measures cover how health care is provided or how the system works. They indicate whether the system is performing as planned.	✦ Outcome measures are critical, but typically require a longer period of time to evaluate. ✦ The final product, results. They could be health status or another measure that indicates whether or not the change made a difference (e.g., mortality or decreased rates of readmission). They demonstrate how the system is performing with a specific result.
Examples ✦ Percent of patients with discharge summary at follow-up ✦ Percent of time hospital admission and discharge data is available at follow-up visit ✦ Moderate and high-risk discharges seen within 5 days (number and percentage). ✦ Frequency of checklist completion ✦ Number of phone calls to reach patients	*Examples* ✦ 30-day all-cause readmission rate ✦ ED utilization ✦ Mortality ✦ Blood Pressure ✦ A1C

Measurement Guidelines
✦ A few key measures that clarify your team's aim and make it tangible should be reported each month.
✦ Be careful about over-doing process measures; try to have one measure for each driver you are working on, but not all the secondary drivers and changes.
✦ Make use of your available data systems for measurement.
✦ Integrate measurement into the daily routine of the systems you are working with. For example, track the number of follow-up visits on a sheet of paper as they come in each week.

See next page for steps

STEPS

Step 1: **Establish a system for tracking discharge information with at least one hospital.** If you do not already have regular communication with your hospital(s) see **Getting data from a hospital.**

Strategies to consider:

1) Keep a list of all discharged patients and keep track of follow-up visits, re-hospitalizations.
2) Use CCNC data on readmissions. (You may have small numbers due to only having a segment of the population.)

Other Data You Want to Collect

- Total number of patients discharged (risk stratified – high, low, moderate)
- Moderate- and high-risk discharges seen within 5 days. (number and percentage).
- Do you complete the checklist?
- Can patients teach back the important content?
- Can we reduce the number of phone calls to reach patients?
- Number of medication 'fixes' we make at each visit
- Patient Satisfaction IHI How-to-Guide's Diagnostic Worksheet
- Do you know when your patients are discharged?
- Do you get patients into the clinic within 5 days for follow-up?
- Do you have discharge summary before visit?
- Is the medication list reconciled?

Step 2: **Develop a Key Driver Diagram to go with your charter.** (See page 12)

Step 3. **Measure care transitions processes at least for the patients discharged from the hospital in Step 1.**

1) Percent of high- & moderate-risk patients seen within 5 days of discharge (process)
2) Percent of first post-hospital follow-up visits when provider had discharge summary at time of appointment (process)
3) Percent of patient discharges practice is notified of within 24 hours of discharge (process)
4) Percent of patients readmitted for any cause within 30 days of hospital discharge (outcome)

Step 4. **Record & chart the following measures monthly:**

1) Admissions from practice
2) 30-day readmissions
3) Percent of 30-day readmissions

Report these measures for the entire patient population (if possible) and the Medicaid population. Medicaid data likely to be available now.

1 | Appendix – Getting Started

1. Care Transitions Processes Assessment Tool
2. IHI Observation Guide: Observing Current Processes for the First Post-Hospital Visit
3. IHI Diagnostic Worksheet
4. PDSA Worksheet
5. Roles and Responsibilities
6. Care Transitions Charter and Aim Statement Template
7. Examples of Charters and Aim Statements

CARE TRANSITIONS PROCESSES ASSESSMENT TOOL

Qualities to consider as you assess your practice's care transitions processes ➔ Reliable ⬧ Accurate ⬧ Comprehensive ⬧ Timely ⬧ Effective ⬧ Sustainable

	No process	Being planned	Works poorly	Works somewhat	Works well	What makes it work?	What causes it not to work?
Timely Access to Care							
1. Knowing when patients have visited the ED, been admitted to the hospital, are going to be discharged and have been discharged	1	2	3	4	5		
2. Making post-discharge appointments based on patients' diagnoses	1	2	3	4	5		
3. Providing advice line or telephone access to a provider after-hours	1	2	3	4	5		
Post-Discharge Visit Planning							
4. Reviewing discharge summaries prior to patient visit	1	2	3	4	5		
5. Preparing patients for the post-discharge visit & identify needs related to attending the visit (e.g., transportation, translation, etc.)	1	2	3	4	5		
Patient Assessed & Care Plan Created/Updated							
6. Eliciting patient goals for post-discharge visit	1	2	3	4	5		
7. Determining factors contributing to hospitalization or ED visit	1	2	3	4	5		
8. Reconciling medication	1	2	3	4	5		
9. Assessing & adjusting medication	1	2	3	4	5		
10. Reviewing test results	1	2	3	4	5		

CARE TRANSITIONS PROCESSES ASSESSMENT TOOL

Qualities to consider as you assess your practice's care transitions processes ➔ Reliable ⬩ Accurate ⬩ Comprehensive ⬩ Timely ⬩ Effective ⬩ Sustainable

	No process	Being planned	Works poorly	Works somewhat	Works well	What makes it work?	What causes it not to work?
11. Ordering new tests	1	2	3	4	5		
12. Educating patients to recognize & respond appropriately to warning signs/red flags using teach back	1	2	3	4	5		
13. Providing instructions for after-hours emergency and non-emergency care using teach back	1	2	3	4	5		
14. Instructing patients in self-management using teach back	1	2	3	4	5		
Care Plan Communicated							
15. Providing reconciled, dated medication list to patient, family, care manager, home health nurse, etc.	1	2	3	4	5		
16. Communicating care plan to patient, family, care manager, home health nurse, etc.	1	2	3	4	5		
17. Making next appointment	1	2	3	4	5		
18. Referring patient to appropriate community resources	1	2	3	4	5		

Observation Guide: Observing Current Processes for the First Post-Hospital Visit

Reflections after observations are completed (to be shared with the entire team)

What did you learn?

How did your observations compare to the predictions?

What, if anything, surprised you?

What new questions do you have? What are you curious about?

What assumptions that you held previously are now challenged?

As a result of the findings from these observations, what do you plan to test?

1.

2.

3.

4.

Excerpt from IHI How to Guide *Improving Transitions from the Hospital to the Clinical Office Practice*[1] *(page 76). Reprinted with permission from IHI, August 2013.*

Diagnostic Worksheet: Interviews with Patients, Family Members, and Care Team Members about a Recent Rehospitalization

Ask Patient and/or Family Members:

How do you think you became sick enough to be readmitted to the hospital?

Did you have a physician office visit before returning to the hospital?

Yes ☐ If yes, which doctor (PCP or specialist) did you see? No ☐ If no, then why not?

Describe any difficulties you encountered in scheduling or getting to that office visit.

Has anything (e.g., appointments) gotten in the way of your taking your medicines?

How do you take your medicines and set up your pills each day?

Describe your typical meals since you got home.

Interview physicians, nurses, or others who know the patient. Include clinicians and staff from the hospital, skilled nursing facility, and/or home health as appropriate.

Ask care team members:

What do you think caused this patient to be readmitted to the hospital?

After talking to the care team members about why they think the patient was readmitted, write a brief story about the patient's circumstances that contributed to the readmission.

Excerpt from IHI How to Guide *Improving Transitions from the Hospital to the Clinical Office Practice* [1] *(page 73). Reprinted with permission from IHI, August 2013.*

PDSA Worksheet Template

Aim: (overall goal you wish to achieve)

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done

Plan:			
List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds

Do: (Describe what actually happened when you ran the test)

Study: (Describe the measured results and how they compared to the predictions)

Act: (Describe what modifications to the plan will be made for the next cycle from what you learned)

Post-Hospital Follow-Up Visit Roles and Responsibilities Table

Task	Joe	Mary	Dr. Smith	
Prior to Visit				
Identify patient discharge	x			
Get discharge summary	x			
Review dc summary			x	
Identify tests needing follow-up			x	
Flag issues needing addressing now			x	
Call to check on patient, remind of appointment		X		
Check with case manager		X		
At the Visit				
Identify patient goals		x		
Patient view of factors leading to hospitalization		X		
Medication review		X	X	
Instructions on when to seek care, warning signs		X		
Plan of care			X	
Self-management instructions		X	X	
Teach back		X	X	
Referral to home health?			X	
After hours care and acute visit information	X			
Follow up scheduled	x			

Care Transitions Improvement Charter & Aim Statement Template

Team Name & Date

Aim Statement – Feel free to modify the suggested language below but do include a numerical goal and a date.

By _____(date), we will improve _____(**name the process or topic**) in _____(**location**) by _____ (**a numerical goal**). By working on the process, we expect _____ (**list benefits**). It is important to work on this now because _____ (**list imperatives.)** Some things we have to keep in mind as we work are _____ (**guidance & scope**).

Examples of Measures –

- Percent of discharged patients who are readmitted for any cause within 30 days of discharge
- Percent of discharged patients who are evaluated in an emergency department for any cause within 30 days of discharge
- Percent of active patients for whom practice is able to receive daily updates about hospital discharges
- Percent of high-risk patients seen within two days of discharge
- Percent of moderate-risk patients seen within five days of discharge
- Percent of first post-hospital visits when the provider had the discharge summary available at the time of the visit
- Percent of patients who received a reminder call prior to their first post-hospital office visit
- Percent of patients who no-show for first follow-up visit following a hospitalization
- Percent of patients who can teach back the medications they should take at home, including dosage and time
- Percent of patients who can teach back the warning signs they should watch for and how to respond
- Percent of patients who leave the first post-hospital visit with a printed and reconciled medication list
- Percent of patients who leave the first post-hospital visit with a printed care plan

Team Members - Who are the right people to make this happen? Look at the process you are improving and assure that those affected by the process are included. Consider representation from:

- Practice leadership
- Clinical experts
- Care managers
- Hospital liaison

- Improvement advisor/coach
- Key staff
- Patient/family representative

Tips:
- *Try to keep charter to one page*
- *Should be understandable to anyone, including the public*
- *Reviewed and accepted by leadership*

Example 1: Care Transitions Improvement Charter

ACME Medical Center   **June 2012**

Aim Statement
By June 2013, ACME Medical Center will reduce patient readmissions by 20% from our current readmission rate. Our practice will accomplish this by implementing the *IHI How-to-Guide: Improving Transitions From the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations*. Our focus will be in 4 key areas: provide timely access to our practice following hospitalization, prepare patient and clinical team for the visit, assessment and care plan development or revision during the follow-up visit, and initiation of a coordinated ongoing care plan.

Practice management feels that overall hospitalization and ED rates (not just readmission rates) will be positively impacted from enhanced access to our practice, better coordination of care for all patients and more focused care management of high risk patients. This, in turn, will enhance patient and staff satisfaction. It is important to work on this now because fragmented and poorly coordinated care transitions have a negative effect on patients' health, well-being, and family resources as well as increase health care costs and disrupt continuity of care. Avoidable re-hospitalizations represent significant waste and inefficiency in the current care delivery system. Some things we need to keep in mind are the multiple hospital entities we interact with and the need to collaborate and establish relationships that will assist us in meeting our goal. We must ensure that we identify and include those that are affected by the process we are working to improve.

Measures: To be evaluated-placeholder for now.
- Percent of discharged patients who are readmitted for any cause within 30 days of discharge
- Percent of discharged patients who are evaluated in an emergency department for any cause within 30 days of discharge
- Percent of active patients for whom practice is able to receive daily updates about hospital discharges
- Percent of high-risk patients seen within two days of discharge
- Percent of moderate-risk patients seen within five days of discharge
- Percent of first post-hospital visits when the provider had the discharge summary available at the time of the visit
- Percent of patients who received a reminder call prior to their first post-hospital office visit
- Percent of patients who no-show for first follow-up visit following a hospitalization
- Percent of patients who can teach back the medications they should take at home, including dosage and time
- Percent of patients who can teach back the warning signs they should watch for and how to respond
- Percent of patients who leave the first post-hospital visit with a printed and reconciled medication list
- Percent of patients who leave the first post-hospital visit with a printed care plan

Team Members: (others may be added on ad hoc basis or if we find we need additional roles represented)
Practice Leadership: Jane Smith—Administrative Office Manager
Clinical Experts: Physician—being identified   Nurse and or MA—being identified
Care Managers: CCWJC—Betsy Doe   Others such as BCBS being identified
Improvement Advisor/Coach—Jane Doe AHEC
Key Staff: front office person ---being identified, medical records and/or referral coordinator
Hospital Liaison—contacts being identified
Patient/Family Representative: idea being discussed

Example 2: Care Transitions Improvement Charter

Charter ACME General Medicine Clinic   June 2012

Aim
By December 2012, we will reduce readmissions of patients served by the ACME General Medicine clinic by 20% from the current readmission rate. We will do this by implementing the *IHI How-to Guide on reducing avoidable rehospitalizations* and focusing on timely access to our practice post hospitalization, preparing the patient and clinical team for the visit, systematic assessment and care plan development during the follow-up visit, and initiation of a coordinated ongoing care plan.

The leadership team's assessment is that hospitalization rates in general (not just rehospitalization) will benefit from enhanced access to our practice and more intensive management of high risk patients. We will expand the care coordination aspect of the readmission program to other high risk patients after establishing a reliable program for avoidable rehospitalization.

Measures
We have several avenues for measurement of the outcomes and they represent different data streams.

Primary Target:
1. Reduce readmissions of any patient admitted to ACME Hospitals by 20% from baseline value. We will work with ACME Hospital data management to establish our baseline for the past year (on a quarterly basis). We will assess progress on the measure quarterly and ask for the following data:
    a. Total admissions over 90 days
    b. Total admissions over the same 90 days followed by a <30 day readmission

Secondary Target:
1. Reduce readmissions for any hospital among patients enrolled in CCNC. Assess the following data as available on the physician's portal:
    a. Total admissions over 90 days in this population
    b. Total admissions over the same 90 days followed by a <30 day readmission.

Process Measures
1. We need to sort this out based on our plan of implementation of each of the pillars in the change package. Good topic for next meeting.

Guiding Coalition
Clinic physicians, care manager, practice manager, pharmacist

Example 3: Care Transitions Improvement Charter

XYZ Practice   **June 2012**

Aim Statement

By 6/30/13 we will improve readmission rates of patients served by XYZ Practice over the current rate in clinic patients discharged from XYZ Hospital by 20%. By working on the process, we expect better access to care post discharge, a decrease in readmission rates and a better coordination of care planning after discharge from XYZ Hospital.

Measures

- Percent of discharged patients who are readmitted for any cause within 30 days of discharge
- Percent of high-risk patients seen within two days of discharge
- Percent of first post-hospital visits when the provider had the discharge summary available at the time of the visit
- Percent of patients who leave the first post-hospital visit with a printed and reconciled medication list

Team Members
   Dr. Jones
    XYZ discharge nurse
   Clinical staff
   CCNC Care Mgr
    AHEC QIC

Example 4: Care Transitions Improvement Charter

Family Care Clinic   **June 2012**

Aim

By 6/30/13 we will improve readmission rates of patients served by Family Care Clinic over the current rate in clinic patients discharged from Memorial Hospital by 20%. By working on the process, we expect better access to care post discharge, a decrease in readmission rates and a better coordination of care planning after discharge from Memorial Hospital.

Measures – Consider for Measurement

- Percent of discharged patients who are readmitted for any cause within 30 days of discharge
- Percent of high-risk patients seen within two days of discharge
- Percent of moderate-risk patients seen within five days of discharge
- Percent of first post-hospital visits when the provider had the discharge summary available at the time of the visit
- Percent of patients who leave the first post-hospital visit with a printed and reconciled medication list

Team Members
Provider
Practice Manager
CCNC Care Manager
Memorial Hospital Ns
AHEC QIC

Example 5: Care Transitions Improvement Charter

ABC Community Health Center   June 17th 2012

Aim Statement
By June 2013 ABC CHC will reduce patient readmissions by 20% from our current readmission rate.

We will use the *IHI How-to-Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalization*. Our focus will be in 4 key areas: provide timely access to our practice following hospitalization, prepare patient and clinical team for the visit, assessment and care plan development or revision during the follow up visit and initiation of a coordinated ongoing care plan.

We believe that hospitalization in general and ED visits not just rehospitalizaton will benefit from improving access to our practice and a more collaborative management of high risk patients. It will be important to keep in mind that this will entail a collaborative effort and a strong relationship between the hospitals and our practice in a care plan for patients that will serve to improve the health and wellbeing of patients and at the same time decrease health care costs.

Measures
1. Percent of discharged patients who are readmitted for any cause within 30 days of discharge
2. Percent of discharged patients who are evaluated in an emergency department for any cause within 30 days of discharge
3. Percent of active patients for whom practice is able to receive daily updates about hospital discharges
4. Percent of high risk patients seen within 3 days of discharge
5. Percent of moderate risk patients seen within five days of discharge
6. Percent of first post-hospital visits when the provider had the discharge summary available at the time of the visit.
7. Percent of patients who no-show for first follow-up visit following a hospitalization
8. Percent of patients who can teach back the medications they should take at home, including dosage and time.
9. Percent of patients who teach back the warning signs they should look for and how to respond
10. Percent of patients who leave the first post-hospital visit with a printed and reconciled medication list
11. Percent of patients who leave the first post – hospital visit with a printed care plan.

Team Members: (others may be added on ad hoc basis or if we find we need additional roles represented)
Practice Leadership: Medical director
Clinical Experts: Dr. Smith, Dr. Brown, Nurse and or MA – to be identified
Key Staff: registrar, medical records coordinator
Care Manager: TBA

Example 6: Care Transitions Improvement Charter

QRS Family Medicine   5/29/2012

Aim Statement

By June 2013, QRS Family Medicine will reduce patient readmissions by 20% from our current readmission rate. Our practice staff will accomplish this by implementing the *IHI How-to-Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations*. Our focus will be in 4 key areas: provide timely access to our practice following hospitalization, prepare patient and clinical team for the visit, assessment and care plan development or revision during the follow-up visit, and initiation of a coordinated ongoing care plan.

ED visits are also important to monitor. Practice management feels that overall hospitalization and ED rates (not just readmission rates) will benefit from enhanced access to our practice, better coordination of care for all patients and more focused care management of high risk patients. This, in turn, will enhance patient and staff satisfaction. It is important to work on this now because fragmented and poorly coordinated care transitions have a negative effect on patients' health, well-being, and family resources as well as increase health care costs and disrupt continuity of care. Avoidable re-hospitalizations represent significant waste and inefficiency in the current care delivery system. Some things we need to keep in mind are the multiple hospital entities we interact with and the need to collaborate and establish relationships that will assist us in meeting our goal. We must ensure that we identify and include those that are affected by the process we are working to improve.

Measures: To be evaluated-placeholder for now.
- Percent of discharged patients who are readmitted for any cause within 30 days of discharge
- Percent of discharged patients who are evaluated in an emergency department for any cause within 30 days of discharge
- Percent of active patients for whom practice is able to receive daily updates about hospital discharges
- Percent of high-risk patients seen within two days of discharge
- Percent of moderate-risk patients seen within five days of discharge
- Percent of first post-hospital visits when the provider had the discharge summary available at the time of the visit
- Percent of patients who received a reminder call prior to their first post-hospital office visit
- Percent of patients who no-show for first follow-up visit following a hospitalization
- Percent of patients who can teach back the medications they should take at home, including dosage and time
- Percent of patients who can teach back the warning signs they should watch for and how to respond
- Percent of patients who leave the first post-hospital visit with a printed and reconciled medication list
- Percent of patients who leave the first post-hospital visit with a printed care plan

Team Members: (others may be added on ad hoc basis or if we find we need additional roles represented)
Practice Leadership: John Doe-- Office Manager
Clinical Experts: John Smith, PA-C, President of practice
Clinical Staff: Sarah Smith, CNAII and Clinical Director, Mary Jones, MA
Care Managers: Jane Brown and Linda Blair, RN CCNC and PCHD
Improvement Advisor/Coach—Sue Jones AHEC
Key Staff: Mary Doe, (front staff) and Joy Doe (billing and insurance)
Hospital Liaison—TBD-being discussed
Patient/Family Representative: not applicable at the current time

Aim Statement Examples

Aim Statement: Readmission rates for HIJ Internal Medicine clinic continue to show a need for improvement in the transition of care process of patients being discharged from the Regional Medical Center hospital and ED to the clinical setting. Our Impact Transitions Team will reduce readmission rates of Medicaid patients aged 21-65 served by HIJ Internal Medicine in Mayberry, NC. We will decrease the readmission rate from 18.6 % to 15% by December 2013. We will do the work by being a part of the Impact Care Transitions collaborative, using the IHI How-to Guide and PDSA cycles to test changes.

Aim Statement: Research has shown that a smooth transition of care between facilities and providers is an important component in reducing patient readmissions to acute care facilities. ABC Care, a Federally Qualified Health Center, will improve processes around Transitional Care among Medicaid Diabetic and Hypertension patients who are seen in the ED and inpatient setting in the Greensboro, NC metro area back to the clinical practice with the goal of reducing the readmission rate by 5-7% from the July 2011-November 2011 readmission average of 20.06% within 18 months. We will use a Model of Improvement with PDSA cycles of change to improve processes around care transition.

2 | Appendix – Providing Timely Access to Care

1. Risk-Stratified Care Management and Coordination (chart from American Academy of Family Physicians)
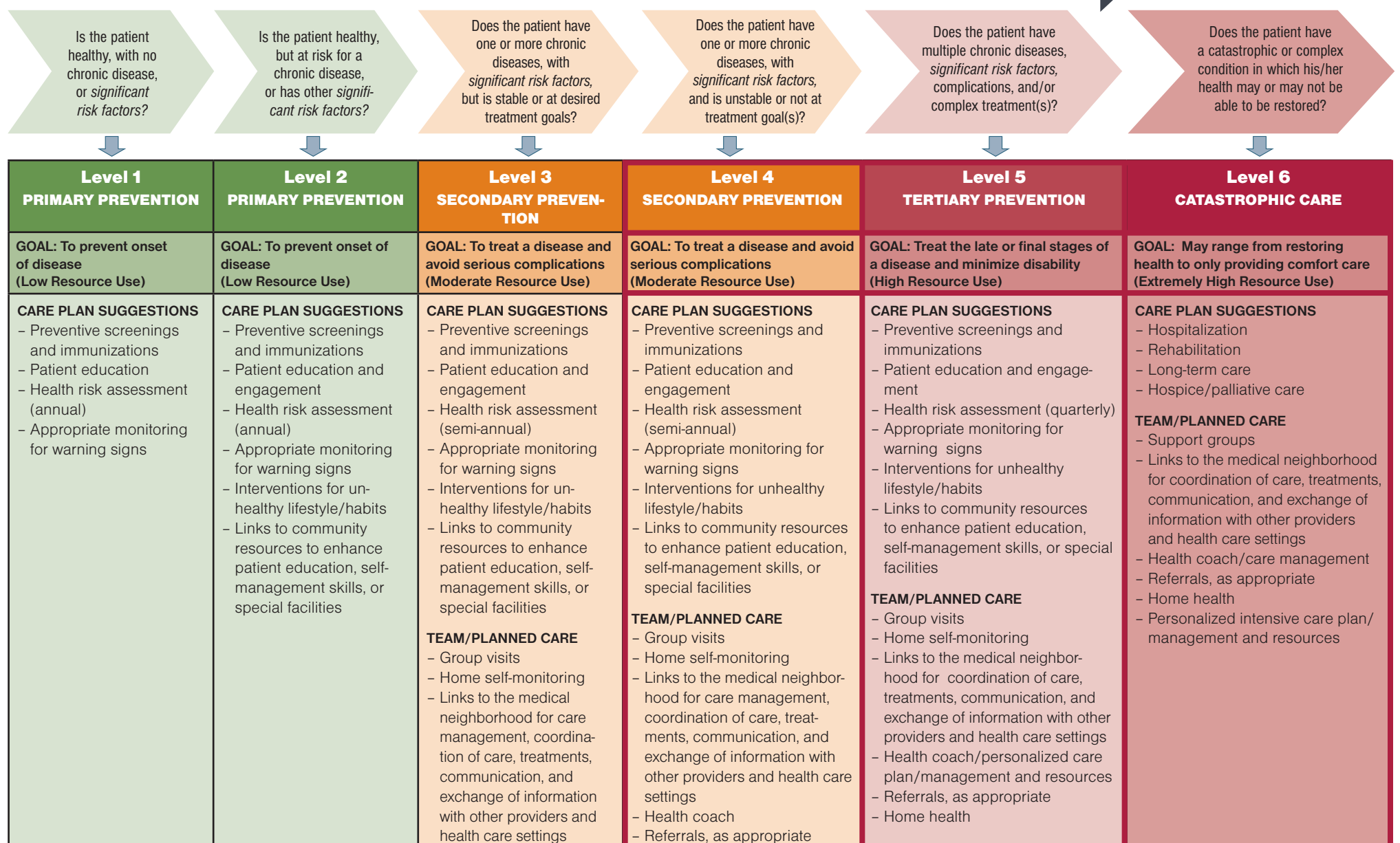2. Sample PDSAs

Risk-Stratified Care Management and Coordination

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Table 1: Examples of Potentially Significant Risk Factors

Clinical Diagnoses, Behavioral Health, Special Needs	Potential Physical Limitations	Social Determinants	Utilization/Claims Data	Clinician Input (Personal Knowledge)
– Any chronic disease, particularly one that is not in control or at desired goal – Chronic pain – Substance abuse (alcohol/drug/tobacco) – Terminal illness – Advanced age with frailty – Multiple co-morbidities – Pre-term delivery of newborn – Child, youth, or adult with special needs – Anxiety, schizophrenia, bipolar, depression, or other behavior affecting health – Dental health – Dementia/Alzheimer's disease	– Non-ambulatory – Needs Assistance with Activities of Daily Living (ADLs) – Severely diminished functional status – Declining eyesight – Extreme weakness or fatigue – At risk for falls	– Lack of financial or family support that impacts care – Unemployed – No health insurance – Low health literacy – Unsafe home environment – Homeless – Lives alone and needs assistance with ADLs – Transportation for health care appointments is difficult – Language barriers	– Frequent hospitalizations (particularly heart failure, GI disorders, and pneumonia) – Frequent office, ER, or urgent care visits – Multiple providers – Hospital readmission within 30 days – Major procedure in last year – Chronic kidney disease – Brain trauma – Expensive medications	– Polypharmacy – Patient is taking several medications that may not all be needed and/or could have potential for interactions – High-risk medications – Non-compliant with treatment plan – Confusion with medications or following the treatment plan – Recent move to long-term facility or other transition of care – Spouse (who was the caregiver) recently deceased – Lack of engagement in care plan – Low confidence or ability for self-management – Answer to the question: Is this patient at higher risk for dying within the next year?

Table 2: Risk Categories and Levels using Diabetes Example Case

CATEGORY	PRIMARY PREVENTION (Low Resource Use) GOAL: To prevent onset of disease		SECONDARY PREVENTION (Moderate Resource Use) GOAL: To treat a disease and avoid serious complications		TERTIARY (High Resource Use) GOAL: To treat the late or final stages of a disease and minimize disability	CATASTROPHIC/COMPLEX (Extremely High Resource Use) GOAL: May range from restoring health to only providing comfort care
Stage	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
	No known diagnoses or complex treatments	No known diagnoses but demonstrates warning signs or potentially significant risk factors	Has diagnosis, but stabilized or in control; potentially significant risk factors	Has diagnosis and/or complex treatment, and at higher risk for complications or potentially significant risk factors	Has diagnosis, complex treatment, and complications or potentially significant risk factors– goal is to prevent further complications	• Very severe illness or condition and potentially significant risk factors • End-of-life care • Premature baby (May have high costs with limited or no opportunity for improvement, stabilization, or cost control)
Example of using uncontrolled progression of diabetes	• Healthy	• Blood glucose and lipids rising, but still within desired parameters • BMI elevated • Smoker	• Diagnosed with type 2 diabetes, blood sugar, and lipids brought within desired parameters • Married, family involved	• Blood sugar and lipids not within desired parameters, and financial situation impacting negatively • Lives alone • One ER visit and one hospitalization in past year	• Has diabetes with early renal disease, coronary artery disease, failing eyesight, and lives alone • Three ER visits and two hospitalizations in past year • Dual eligible Medicaid/Medicare • Needs Assistance with Activities of Daily Living (ADLs)	• Diagnosed with lung cancer • Recent myocardial infarction • Progression to ESRD with renal dialysis • Amputation of one leg • Blind • Lives in nursing home
Example of Care Plan Considerations for patient with uncontrolled progression of diabetes	✓ Preventive screenings and immunizations ✓ Patient education and engagement ✓ Appropriate monitoring for warning signs ✓ Health risk assessment (annual) ✓ Care plan that includes smoking cessation counseling and program offered		✓ Preventive screenings and immunizations ✓ Patient education and engagement ✓ Appropriate monitoring ✓ Health risk assessment (semi-annual) ✓ Care plan with smoking cessation counseling and program offered ✓ Team/planned care ✓ Group visits ✓ Health coach ✓ Referrals as appropriate, such as social services ✓ Community resources ✓ Home self-monitoring		✓ Preventive screenings and immunizations ✓ Patient education and engagement ✓ Appropriate monitoring ✓ Health risk assessment (quarterly) ✓ Intensive care management plan and resources ✓ Smoking cessation ✓ Group visits ✓ Health coach ✓ Home health	✓ Hospitalization ✓ Rehabilitation ✓ Long-term care ✓ Hospice ✓ Home health ✓ Individualized intensive care management and coordination ✓ May or may not conduct preventive screenings ✓ Health risk assessment, as appropriate

Identifying Disease Burden and Determining Health Risk Status

Is the patient healthy, with no chronic disease, or *significant risk factors*?	Is the patient healthy, but at risk for a chronic disease, or has other *significant risk factors*?	Does the patient have one or more chronic diseases, with *significant risk factors*, but is stable or at desired treatment goals?	Does the patient have one or more chronic diseases, with *significant risk factors*, and is unstable or not at treatment goal(s)?	Does the patient have multiple chronic diseases, *significant risk factors*, complications, and/or complex treatment(s)?	Does the patient have a catastrophic or complex condition in which his/her health may or may not be able to be restored?

Level 1 PRIMARY PREVENTION	Level 2 PRIMARY PREVENTION	Level 3 SECONDARY PREVENTION	Level 4 SECONDARY PREVENTION	Level 5 TERTIARY PREVENTION	Level 6 CATASTROPHIC CARE
GOAL: To prevent onset of disease (Low Resource Use)	**GOAL: To prevent onset of disease** (Low Resource Use)	**GOAL: To treat a disease and avoid serious complications** (Moderate Resource Use)	**GOAL: To treat a disease and avoid serious complications** (Moderate Resource Use)	**GOAL: Treat the late or final stages of a disease and minimize disability** (High Resource Use)	**GOAL: May range from restoring health to only providing comfort care** (Extremely High Resource Use)
CARE PLAN SUGGESTIONS – Preventive screenings and immunizations – Patient education – Health risk assessment (annual) – Appropriate monitoring for warning signs	**CARE PLAN SUGGESTIONS** – Preventive screenings and immunizations – Patient education and engagement – Health risk assessment (annual) – Appropriate monitoring for warning signs – Interventions for unhealthy lifestyle/habits – Links to community resources to enhance patient education, self-management skills, or special facilities	**CARE PLAN SUGGESTIONS** – Preventive screenings and immunizations – Patient education and engagement – Health risk assessment (semi-annual) – Appropriate monitoring for warning signs – Interventions for unhealthy lifestyle/habits – Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** – Group visits – Home self-monitoring – Links to the medical neighborhood for care management, coordination of care, treatments, communication, and exchange of information with other providers and health care settings	**CARE PLAN SUGGESTIONS** – Preventive screenings and immunizations – Patient education and engagement – Health risk assessment (semi-annual) – Appropriate monitoring for warning signs – Interventions for unhealthy lifestyle/habits – Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** – Group visits – Home self-monitoring – Links to the medical neighborhood for care management, coordination of care, treatments, communication, and exchange of information with other providers and health care settings – Health coach – Referrals, as appropriate	**CARE PLAN SUGGESTIONS** – Preventive screenings and immunizations – Patient education and engagement – Health risk assessment (quarterly) – Appropriate monitoring for warning signs – Interventions for unhealthy lifestyle/habits – Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** – Group visits – Home self-monitoring – Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings – Health coach/personalized care plan/management and resources – Referrals, as appropriate – Home health	**CARE PLAN SUGGESTIONS** – Hospitalization – Rehabilitation – Long-term care – Hospice/palliative care **TEAM/PLANNED CARE** – Support groups – Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings – Health coach/care management – Referrals, as appropriate – Home health – Personalized intensive care plan/management and resources

11/12

PDSA 1 – Risk stratification (Cycle 1 of 1)

PLAN

Objective for this cycle
Determine readmission and ED visit risk stratifications (high-moderate) for our patient population that can be used on a test review of our patients.

Questions
What information is already out there in the literature? What do studies already say?
What will be the best predictors for our patients? Will readmits and ED visits mirror each other in terms of risk factors?

Predictions
Literature and studies done will already have good information. No need to re-invent the wheel and we should learn from what has already been done. Readmits and ED visit risk factors/criteria will overlap.

Plan for change or test: who, what, when, where
During week of 6/18/12 Ms R will research literature and studies already done.
Ms R will also review high volume practice diagnoses.

Plan for collection of data: who, what, when, where
Same as noted above.

DO

Carry out the change or test. Collect data and begin analysis. Describe observations, problems encountered, and special circumstances.
Here are the links researched which had some really good info:
1. http://www.sciencedaily.com/releases/2010/10/101013082813.htm
2. http://hospitalmedicine.ucsf.edu/downloads/redefining_readmission_risk_factors_for_general_medicine_patients_vidyarthi_auerbach.pdf

STUDY

Complete analysis of data. Summarize what was learned.
Based on review of literature, studies already done and RFM high volume practice diagnoses, we decided to start with the following risk stratification.

Patients with Inpatient readmissions

High risk	Moderate risk
Elderly	Medicaid (low socioeconomic status)
Poor nutritional status (underweight)	Depression
High risk diagnoses - CHF, renal disease, cancer, COPD, infection at discharge	Number of medications (increased risk for interactions)
High risk medications - steroids, narcotics	

Patients with Emergency Dept visits - feel the risk factors would be similar to hospitalization since that is where patients get admitted from...

High risk	Moderate risk
Medicaid	High risk diagnosis—asthma, CHF, COPD
Age > 65	Multiple Medications
Lack of PCP relationship	

ACT

Are we ready to make a change? Plan for the next cycle.
Risk stratification needs more discussion—also need to discuss pediatrics more….plan to test the inpatient readmission criteria on our 4 previous readmits we reviewed at the beginning of our project

PDSA 2 – Risk stratification: Testing criteria (Cycle 1 of 1)

PLAN
Objective for this cycle Test draft of potential high-risk criteria for hospital readmit patients for our practice population. **Questions** Will review of patient charts reflect this criteria? Will review of records identify other criteria not previously considered? **Predictions** For the most part, with so many patients with chronic conditions, it may be best to look at disease conditions. It may be difficult to differentiate high risk versus moderate risk. **Plan for change or test: who, what, when, where** Ms. D will review 5 records of ABC Medical Center readmission patients for applicability of the drafted criteria for high risk only. This will be done during the week of 6/25/2012. **Plan for collection of data: who, what, when, where** Draft criteria based on review of prevalent diagnosis groups in the practice: **High risk:**   patients with dx of COPD, CHF, uncontrolled asthma or diabetes. Ms. D will review the 5 readmission records and assess/record if draft criteria present and good indicator of reason for readmission.

DO
Carry out the change or test. Collect data and begin analysis. Describe observations, problems encountered, and special circumstances. Review of records validated all of the high risk criteria diagnoses except uncontrolled asthma—this is because we did not review any pediatric readmissions and this is one of the most common admissions for peds. One patient had dx of SOB but was attributed to COPD.

STUDY
Complete analysis of data. Summarize what was learned. These diagnoses were validated, however, there may be others and should we look to broaden criteria such as looking at care alerts. We also need to look at moderate criteria and how might that be different. This also was a small sample at one time so we need to review more records. We also feel the same diagnoses will pertain to ED visits as well as incorporating care alerts into our criteria. We also feel we need to look at how to better incorporate care alerts into our patient management.

ACT
Are we ready to make a change? Plan for the next cycle. Review literature and see if new ideas emerge. Try and draft high risk/moderate risk for both readmissions and ED visits and set up new PDSA to test.

PDSA 3 – Risk stratification: Using CCNC Informatics Center data (Cycle 1 of 2)

Aim: (overall goal you wish to achieve)

Obtain data on admissions, readmissions and ED visits on our target population of ABC Practice patients with diagnosis of Diabetes and Hypertension.

Plan:

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
Pull data from CCNC Informatics Center Having data available at the practice level that Practice Identifies Carolina Access Medicaid from our targeted Population	Program manager	Before June 14	ABC Practice

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
We will have baseline data for this project and we will be able to risk stratify these patients according to the Care Transitions project guidelines (Second PDSA).	

Do: (Describe what actually happened when you ran the test)

I was able to go into the CCNC Informatics Center and obtain data from CCNC's S1 patient list. This list was sorted by ABC Practice patients. The patient list was further sorted by Diabetics admissions, readmission, then ED visits. This procedure was repeated for patients with Hypertension.
I had no problems or surprises obtaining the data.

Study: (Describe the measured results and how they compared to the predictions)

Diabetics- 509/8124 enrolled patients   HTN patients 1071 /8124 enrolled patients
 17 had one or more readmissions   27 had one or more readmissions
111 had one or more admissions   199 had one or more admissions
 221 had one or more ED visits   465 had one or more ED visits.

Act: (Describe what modifications to the plan will be made for the next cycle from what you learned)

What action are we going to take as a result of this cycle (Adopt, Adapt or Abandon)? Are we ready to implement the change? We are going to Adopt the data. Readiness to implement change????
We now know that we will be able to collect data for our monthly audits using this process

What are the objectives of the next cycle?
To use the generated list of DM/ HTN patients to develop a Risk stratification method for those patients using the Risk Stratification Measures guidelines identified on the Care Transitions List Serve Site.

PDSA 4 – Risk stratification: Using CCNC Informatics Center data (Cycle 2of 2)

Aim: (overall goal you wish to achieve)

Stratify the risk of Medicaid Diabetics and Hypertensive patients following the Risk Stratification Measures identified on the Care Transitions List Serv Site.

Plan:

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
Can we stratify the risk of our data population to ABC Practice staff TBD ABC Practice identify patients who are potentially candidates member TBD for admission or readmissions to the hospital setting?	ABC Practice staff member	TBD	ABC Practice

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
We will be able to identify patients Who are at risk for admission or readmissions to the hospital setting using the risk stratification measures identified on The Care Transitions List Serve site.	

Do: (Describe what actually happened when you ran the test)

Study: (Describe the measured results and how they compared to the predictions)

Act: (Describe what modifications to the plan will be made for the next cycle from what you learned)

PDSA 5 – Assessing the practice: Flagging 30-day readmissions (Cycle 1 of 4)

Aim: (overall goal you wish to achieve)
Identify 30 day readmissions to help assess the need for work on care transitions

Plan:	
List the tasks needed to set up this test of change	**Person responsible**
Flag charts for 30 day readmissions Determine if use of EMR "sticky note" is an effective way to notify clinic of 30 day readmission.	Nurse care manager and hospital follow-up staff **Where:** at ABC clinic

Predict what will happen when the test is carried out	**Measures to determine if prediction succeeds**
Use of sticky note is a good way to notify of readmissions	

Do: (Describe what actually happened when you ran the test)
CCNC care coordinators were responsible for posting 30 day readmit patients on "sticky note" in EMR record. Hospital follow-up staff to automatically check all HFU records for documentation on EMR for sticky note. If 30 day readmit note present, staff to place green paper on chart so clinic staff and MD are aware. CCNC had one patient be transferred to SNF. One client was known to have hx. Of frequent no-show.

Study: (Describe the measured results and how they compared to the predictions)
CCNC care managers did not feel this new process was difficult to implement. HFU staff to be determined after interview on Monday. Clinic RN was aware that new process was implemented but did not hear any feedback around new process.

Act: (Describe what modifications to the plan will be made for the next cycle from what you learned)
Please see above information. Is this feasible long-term or there are other suggestion for change related to 30 day readmission notification? That is to be determined. **What are the objectives of the next cycle?** If sticky note process is adopted the next PDSA is to determine what the actual roles of the ABC Clinic staff and CCNC social work (SW) staff. Clear role delineation is essential in helping to determine how to potentiate coordination of care for our most difficult clients.

PDSA 6 – Assessing the practice: Mapping workflow (Cycle 2 of 4)

Aim: (overall goal you wish to achieve)
Develop a process map of social worker (MSW) work flows in clinic to better define roles and responsibilities for care transitions

Plan:	
List the tasks needed to set up this test of change	**Person responsible**
Map workflow of social worker and care management roles within clinic.	CCNC Program Manager, AHEC QIC, CCNC Care Managers **Where**: at ABC clinic
Predict what will happen when the test is carried out	**Measures to determine if prediction succeeds**
There is limited understanding about the role of the care manager vs. social worker within the clinic and between the two disciplines themselves.	

Do: (Describe what actually happened when you ran the test)
Developed a process map of MSW workflows in clinic. There were multiple assumptions about the different job responsibilities within the clinic. The ABC Clinic MSW has no set guidelines or job descriptions within the clinic. This causes lines to be blurred about job responsibilities within the clinic (i.e., new mental health professional hired recently in clinic; MSW felt a particular referral should have come to her; instead it went to the mental health professional). Also no absolute vehicle for referrals identified, referrals are made in a variety of ways to care managers and to SW; email, walking referrals over, etc. Needed to establish communication pathways between clinic MSW and CCNC MSW as well.

Study: (Describe the measured results and how they compared to the predictions)
The predictions were true. There was some surprise as to the level of clear lines of communication, lack of policy and job descriptions. ABC Clinic MSW and care managers have established ways to communication and although nothing is written in stone, it does not seem to limit patient care. It was identified that because the nursing staff does not have official way to communicate with MSW or care managers, things are not done as expeditiously as possible.

Act: (Describe what modifications to the plan will be made for the next cycle from what you learned)
Because the care managers and MSW did not have problems with communication, we felt it was not a big issue between them. However, the roles and duties of the MSW and CCNC staff were of an issue for **the clinic staff, especially within the nursing department**. The ability to communicate with the ABC Clinic and the CCNC MSW was important if outpatient f/u was necessary (i.e., home visit). Another issue would be how to have ability for ABC Clinic to have read-only ability in CMIS if needed or CCNC MSW to communicate finding in EMR for ABC Clinic MSW. **What are the objectives of the next cycle?** To meet with the Nursing clinical supervisor and/or the hospital follow-up nurse at ABC Clinic, John Smith To meet with the medical director, Dr. Jane Doe. To discuss or meet with the Registration Supervisor, Jane Brown.

PDSA 7 – Assessing the practice: Mapping hospital follow-up clinic nurse workflow (Cycle 3 of 4)

Aim: (overall goal you wish to achieve)
Overview of hospital follow-up clinic nurse workflow to better understand where gaps are

QUESTIONS
What is the ABC hospital follow-up clinic nurse's workflow processes? What is their role with 30-day readmissions? Was the sticky note process helpful?

Plan:	
List the tasks needed to set up this test of change	**Person responsible**
Review hospital follow-up (HFU) clinic nurse's work flow process	ABC Clinical Supervisor, CCNC Program Manager, AHEC QICs, CCNC Care Managers **Where**: at ABC clinic
Predict what will happen when the test is carried out	**Measures to determine if prediction succeeds**
The HFU clinic nurses are not aware if the patient is a 30-day readmission. The 30-day readmission notification via sticky note is useful, but not utilized widely yet. The HFU visits per clinic staff is variable depending on the nurse.	

Do: (Describe what actually happened when you ran the test)
The workflow routine of the unassigned clinic hospital f/u nurse was reviewed; including their pre-room dialogue. Discussion then centered on the sticky note process being incorporated into the routine of the nursing workflow. Because we were focused on Carolina Access II patients as a control group we were only able to use process for 2 identified patients because of the short period of test time with the PDSA. It was determined that the sticky note process would need to be run for a month with an evaluation period every 2 weeks. It was evident that there was a need to know who the repeat ED and 30-day readmits were.

Study: (Describe the measured results and how they compared to the predictions)
We will need to test 30-day readmissions for a longer period of time to help with determination of barriers. The sticky note process is a viable one. We did have a request from the clinical supervisors that the care coordinators add the actual discharge date as well, not just a 30-day readmission

Act: (Describe what modifications to the plan will be made for the next cycle from what you learned)
*Have all green sheets placed in the halls for use with 30-day readmissions to help with documentation of barriers *Notify providers of this new process; as well as nursing staff of new process. *Have a centralized location for collection of the data found on the green sheet. *CCNC to send list of 30-day readmissions to clinical supervisor in 2 weeks. *Make sure CCNC places 30-day readmit discharge date on sticky note as well. *Clinical staff to begin also assess for barriers through pre-room conversation **What are the objectives of the next cycle?** To test the sticky note process for a longer period of time to determine if this is viable workflow to implement clinic wide.

PDSA 8 – Assessing the practice: Discuss workflow with medical director (Cycle 4 of 4)

Aim: (overall goal you wish to achieve)
To have the input on clinic workflow related to 30-day readmissions and need for medical director leadership in this process.

Plan:	
List the tasks needed to set up this test of change	**Person responsible**
Meet with medical director to determine the concerns related to 30-readmissions and how the clinic workflows impact the physician.	ABC medical director, CCNC Program Manager, CCNC Care Manager **Where**: at ABC clinic

Predict what will happen when the test is carried out
Medical director to identify workflow "holes" that impact the physician.

Do: (Describe what actually happened when you ran the test)
Medical Director had a good understanding of the purpose for sticky note process. We asked the physician to let the other doctors know of this new PDSA. The MD identified that the system is broken; not so much on the clinic end but starting in the hospital setting. She notes if residents that round in the hospital a have particular concern about patient f/u they have to make the call in order to get an appointment made in a timely manner. She felt this should be done by the hospital discharge planners. Also, MD thought it would be a good to have a real voice make reminder calls for pre-clinic visit instead of auto calls.

Study: (Describe the measured results and how they compared to the predictions)
Yes. MD explained the workflow process from a medical standpoint and verified what was beneficial. *There seemed to be quite a bit of discussion around failure within the hospital discharge process. Good also to have clarity shed on the roles of the residents versus the faculty medical staff.*

Act: (Describe what modifications to the plan will be made for the next cycle from what you learned)
Medical director to notify the physicians of the PDSA for identification of the 30-day readmissions. MD also made aware that once these cycles are complete we will compile all the information and present to the administration. **What are the objectives of the next cycle?** To complete PDSA with registration coordinator to look at workflows and then observe if what they state and what they do is the same process. #2. We will also look at whether implementing a live calling system is doable vs. the automated system and what information is verified from the hospital discharge planner related to demographics and what is communicated to the patients once they are contacted.

PDSA 9 – Discharge information: Establishing contact at hospital (Cycle 1 of 1 planning)

PLAN
Objective for this cycle Establish contact at ABC Hospital and complete gap analysis regarding discharge notification and receipt of discharge summary. **Questions** Will we be able to identify primary contact? Who are the key people that need to be involved? Will facility contact be willing to work with us on gap analysis? **Predictions** Care manager will be very helpful re: ABC Hospital contact. We will be able to establish contact/key people to work with us to complete gap analysis. **Plan for change or test: who, what, when, where** Within the next week, Jane will contact G. at ABC Hospital to start dialogue and establish/verify contact and start planning for gap analysis. **Plan for collection of data: who, what, when, where**

PDSA 10 – Discharge information: Communicating with hospital re. faxed discharge summaries (Cycle 1 of 1)

PLAN
I plan to: Contact ABC Hospital Medical Records to confirm how to secure consistent discharge summaries as a fax was recently sent outlining an automated system for discharge summaries to be sent from medical records, and as of yet, no discharge summaries have been sent. **I hope this produces:** Help the hospital understand our protocol for discharge summaries and contacts in our office to reach out to on behalf of a patient. **Steps to execute:** Contact Jane Doe, Hospitalist Program Coordinator

DO
What did you observe? Hospital is still not sending our practice the discharge summaries as the fax had outlined it would. We contacted Jane Doe to discuss a patient who came to our clinic on the advice of the hospitalist post MI. The patient did not remember when she was admitted or exactly what her discharge instructions were. She had a pressure dressing as a result of what she thought was a cardiac procedure that she was told would be removed by her primary care provider.

STUDY
What did you learn? Did you meet your measurement goal? Jane Doe said that there is a glitch in the hospital system such that even when patients identify themselves as associated with a practice, they are not able to record that information so the discharge summaries are not being sent out. If they know that their patient is in the hospital or discharged, they can call medical records to have the discharge summary sent to them.

ACT
What did you conclude from this cycle? We need to sign up for regional Health Information Exchange to send us face sheets for our patients. That way we know our patient has been in the hospital, and we can call medical records to have the discharge summary sent over. This will become a pre-work step for patients who call for an appointment post discharge. The application for these services is being filled out. This is temporary as they hope to fix the glitch in EPIC so that primary care practitioner can be identified. Also, eventually, when HIE goes live in late August or September, we will change our workflow to look in the secure inbox for a discharge summary or pull one through if it has not been sent to us.

PDSA 11 – Discharge information: Using patient survey to determine if discharge summary was received after ER visits (Cycle 1 of 1)

PLAN Pediatric Patient Caretaker Survey on After-hours Coverage
Objective for this cycle   Research recent 2 or more ER return visits and evaluate whether we have received the relevant discharge summaries.   **Questions**   Have we received all discharge summaries for ER visits?   **Predictions**   In questioning patients on recent visits to ER, we can evaluate how many discharge summaries have not been received and discuss options to help improve these numbers.   **Plan for change or test: who, what, when, how, where**   Will ask patient if they have been seen in ER in last 90 days, then check patient chart to see if we have received their discharge summaries for these visit. If numerous discharge summaries are found to be missing, we will contact the appropriate person at Regional Hospital to help us evaluate this problem and work toward a solution.   **Plan for collection of data: who, what, when, how, how long**   Will ask patient if they have been seen in the ER or hospitalized over the last 90 days. If patient has been seen in last 90/d then we will search their chart to see if we have received a discharge summary for this visit. We will keep a written record of these to see how many discharge summaries were not received. We will keep this record for one week then evaluate the results.
DO
Carry out the change or test. Collect data and begin analysis. Describe observations, problems encountered, and special circumstances.   We have been collecting data by asking patients if they have been seen in ER in last 90 days.
STUDY
Complete analysis of data. Summarize what was learned.   In the last 7 days we have found that out of 10 patients who reported that they had been seen in the ER within the last 90 days, only one patient had a discharge summary in his chart.
ACT
Are we ready to make a change? Plan for the next cycle.   We are in contact with Jane Doe with Regional Hospital who is part of the hospitalist program. She will help us evaluate why we are not receiving the discharge summaries.

PDSA 12 – Providing Timely Access: Creating capacity for follow-up visits (Cycle 1 of 1)

For the past couple of months our hospital follow-up pilot program has consisted of a Clinical Pharmacist that has seen hospital follow-up patients with an attending physician. For July-August our regular clinical pharmacist will not be in clinic. In order to keep the hospital follow-up clinic, running we must find an alternative method for staffing our clinic.

PLAN
1. Have third year resident's staff our hospital follow-up clinic three half days a week. 2. Freeze slots in 5 attendings' clinics in order to have schedules to place these patients in. 3. Have our social worker call and schedule patients in these frozen slots in order to avoid confusion in our communication's center about where these slots are and who can be scheduled in them. 4. If a patient/ hospital calls to schedule a hospital follow-up appointment the communication center is instructed to place the patient with their PCP, resident clinic, same day clinic, etc.

DO
1. During the hospital follow-up visit the resident will follow our hospital follow-up template. 2. The resident will then precept with the attending who is assigned to work with the resident for the day. 3. The preceptor will evaluate the patient and make any suggestions for care. 4. The resident will then type up the clinic note using the hospital follow-up template. 5. Resident's will collect data on the visit and the patient.

STUDY
1. Collect feedback from residents, preceptors, and social worker in order to determine how the new process works and how we can incorporate residents in the future. 2. Evaluate how our new precepting process of assigning an attending to hospital follow-up clinic is working. 3. Evaluate data that is collected about visits and the patient.

ACT
In the future when our hospital follow-up clinic is staffed by our clinical pharmacist we want to determine if our new precepting process is more efficient. We also want to be able to incorporate resident in our hospital follow-up process.

PDSA 13 – Providing Timely Access: Assessing workflow process re. discharge summaries and scheduling follow-up visits (Cycle 1 of 1)

PLAN

Objective for this cycle

Test workflow process for front desk staff to receive faxed discharge summary, check for follow-up appointment, schedule follow-up appointment based on revised high/moderate risk criteria, put discharge summary on patient chart and get to provider for review prior to appointment.

Questions

How much added work will this be for front desk staff?

Will high/moderate-risk criteria be clear to staff when scheduling appointments—will they have questions?

Will we be able to schedule appointments in the defined timeframes? Will patients keep appointments?

Will providers review charts prior to appointment?

What parameters for f/u visit from the hospital will we see—will they be very different from what we have as our criteria?

Predictions

This will not increase workload unreasonably.

Some questions may arise due to being a new process and unpredictability of patient response.

May not be able to reach all patients.

Discharge summaries may have different parameters for f/u visit.

Plan for change or test: who, what, when, where

Week of July 23, 2012:
- Front office staff will intercept all ED and hospital admission discharge reports/summaries and give to Jane
- Diagnosis and # of days for f/u appointment determined based on revised high/moderate risk criteria (Jane)
- MR checked for scheduled f/u appointment; if none found, or time frame exceeds criteria, patient to be called and scheduled per criteria (Jane)
- After f/u appointment scheduled, front office staff member will put discharge summary on patient chart and give to provider to review—after review, chart to front office staff to be filed

Plan for collection of data: who, what, when, where

Documentation flow sheet devised that will document and keep track of timeframes for each piece of the process being tested. Documentation on flow sheet will be by the front office staff and Jane.

Revised high/moderate risk criteria sheet and timeframe guidelines given to front office staff to follow after educated and questions answered by Jane—these were approved with input from medical director.

High Risk Diagnoses are COPD, CHF, uncontrolled diabetes, uncontrolled HTN

Patients with high risk diagnoses should follow up in the office within 2 days.

Moderate Risk includes all other diagnoses and these patients should follow up in 5-7 days.

These are guidelines only, the discharge instructions from hospital may take precedence over these parameters.

DO

Carry out the change or test. Collect data and begin analysis. Describe observations, problems encountered, and special circumstances.
- Documentation made for each report; documented appointment scheduled
- Documented whether the patient kept the appointment
- Reported the # of days between d/c and follow up appt.
- If appointment not kept (whether cancelled or no show), attempts made to call patient to reschedule; documentation made in chart.
- No problems with attaching dc summary to provider for review and then filed.

  Most appointments not already scheduled and we had to call patients.

No pediatric admits.

STUDY

Complete analysis of data. Summarize what was learned.
 	
Actual Data:
   31 reports total received: 9 ED dc summaries and 22 Hospital discharge summaries
   24 patients were scheduled; all kept their appointments except for 1 (NS x 2)
    5 patients did not return our phone call
    2 patients declined follow up (due to dx and "doing fine" –ex. Viral illness)
   Time range for follow up: 2-12 days; all high risk patients seen within 5 days.
 	
We learned that very few patients who had been admitted or visited the ED voluntarily scheduled a follow up in the office. Only 4 out of 31 were scheduled prior to our calling. Discharge summaries for some patients simply said: "follow-up with primary provider" but no timeframe given.
 	
Uncontrolled diabetes and uncontrolled HTN could be better defined. 2 days for all high risk f/u visits may not be possible. We also need to revisit our risk criteria again based on clearer definitions and do we really want to include any other patient under moderate risk—how can we separate this out more from a low-risk patient?
Also-peds criteria should be more for ED admits as we rarely have an inpatient admit for peds and that is normally asthma.

ACT
We feel the front office workflow change has made a positive impact—we do want to revise our criteria again in order to focus on getting the priority patients in for f/u –how can we determine actual lower risk from moderate risk? Discussion about PDSA with Medical Director planned.

PDSA 14 – Providing Timely Access: Assessing length of time between discharge and follow-up (Cycle 1 of 1)

PLAN

Objective for this cycle

For current appointments scheduled as hospital follow-up: check to see how long it has been since discharge and the follow-up visit. Also check to see if hospital discharge summary in chart.

Questions

For the appointments scheduled as hospital follow-up, were they indeed hospital follow-up visits?
How many days from hospital discharge until seen for hospital follow-up visit?
Were any scheduled hospital follow-up visits cancelled, rescheduled or no show?
Is hospital discharge summary in chart?

Predictions

All appointments scheduled appropriately as hospital follow-up
# of days from hospital discharge to follow-up visit will vary
There will be at least (1) cancellation, reschedule or no show
Most hospital discharge summaries will not be in chart

Plan for change or test: who, what, when, how, where

On Monday 6/18, practice schedule at ABC Medical Center will be reviewed by Jane to view appointments scheduled as hospital follow-up for the week of 6/18-6/22. Based on # of these visits scheduled, one day (or possibly two) 9-5P will be designated as the test day(s). We would like to look at 4-5 patient visits scheduled as hospital follow-up. The front office staff, Ms. H, will review all visits scheduled as hospital follow-up for:

1) Validation that this is a hospital follow-up visit
2) # of days since discharged from hospital and current visit
3) Cancellation, reschedule or no show
4) Hospital discharge summary in chart

Plan for collection of data: who, what, when, where

Ms. H will develop simple check sheet to record data results.
On (1) or (2) designated days during the week of 6/18-6/22, from 9-5P, Ms. H will review scheduled hospital visits for the above 4 items—reviews will be done by pulling records and reviewing prior to patient arrivals. Ms. D will document results on check sheet and tabulate results after all patients seen.

PDSA 15 – Providing Timely Access: Decreasing time from discharge to follow-up (Cycle 1 of 1)

AIM
Transition high-risk patients to medical home by within 5-7 days

PLAN
What change are we testing?   Decreasing the transition time for patients from hospital to medical home.   **What is our prediction?**   We will be able to transition high-risk patients discharged from hospital in the clinic within 5-7 days?   **Who is Responsible?**   Clinical pharmacist, care manager, physician and social worker   **What?**   To successfully have patient scheduled in clinic for discharge review in a timely manner to prevent readmissions.

DO
Describe what actually happened when you ran the test. What did we observe that was not part of the plan? Document problems and surprises.   First open slot day (Wednesday) did not have patients scheduled. We determined turn-around time was too soon after discharge.   One high-risk patient was readmitted before he was seen in clinic; although we believe he rescheduled his Wed. high-risk slot to another day. We had one no-show and we saw one patient successfully.

STUDY
Describe the measured results. Do the results agree with the predictions made in the planning phase?   The timing a 5-7 day transition period is tougher than expected.   The slots were available but the intricacies of this are more complex partly due to fragmentation in care on the hospital resident side. For the patient that was seen, the flow was perfect and demonstrated that this was possible. We still believe we can decrease transition time.

ACT
What action are we going to take as a result of this cycle (Adopt, Adapt or Abandon)? Are we ready to implement the change?   We are going to run the PDSA for two weeks instead of one. We are also going to isolate the PDSA to one internal medicine unit on the hospital side (10 T) and attempt to train and involve the staff. We will work with Dr. Doe to develop a high-risk flag system on admission for all medical staff to understand the importance of the discharge process in order to transition to medical home. Pts. will be given their discharge instructions and appointment time in hand. We will continue focus on the med. rec piece as well. We are not ready to implement the change at this moment.
What are the objectives of the next cycle?   To run the high-risk f/u clinic for two weeks transitioning patients in to practice within 5-7 days.   To involve 10 T staff in the process to increase likelihood that patient will go to medical home   To flag charts as high-risk charts to limit the effects of fragmentation by the medical staff.   To continue to maximize the multidisciplinary approach in the clinic   To increase provider satisfaction in the clinic setting

PDSA 16 – Providing Timely Access: Medical assistants (MAs) contact patients to schedule screenings (Cycle 1 of 2)

AIM (overall goal you wish to achieve)
Increasing the number of patients who received needed screening

Questions
Can MA's fit it into their daily work?　　　Will they feel comfortable?   What support will be needed?　　　Will patients respond to an MA?   If appointments are made, will patients come in and get needed screening?

PLAN

List the tasks needed to set up this test of change	Person responsible
- Jane will print out a list of Dr. Doe's patients who are due for preventive screenings and she, and Dr. Doe will choose 5 patients to call for this first PDSA. - On Tuesday, Jane will call the 5 patients and ask them to make appointments for their screening.	Jane – Medical Assistant (MA) and Dr. Doe

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
It may be hard to fit many calls into the day. If we have a list of patients and the screening needed, it will help get the work done. A script may help. More experienced and confident MA's will have an easier time doing it than less experienced, confident. Patients may make appointments but they won't keep them. Jane, Dr. Doe's MA will do the first round of testing. She is experienced and a good communicator.	PLAN FOR COLLECTION OF DATA: WHO, WHAT, WHEN, WHERE 1. How many calls did Jane make? 2. Did something not get done so these calls could get done? 3. How many patients did she reach? 4. How did patients respond to her calling them about this? 5. How many appointments were made? 6. How was it for Jane? Dr. Doe? 7. How much time did it take? 8. What made it successful or barriers?

DO (Describe what actually happened when you ran the test)

Jane and Dr. Doe chose 5 patients from the list, and on Tuesday Jane was prepared to make the calls. She was able to get 3 calls in during the day and was able to reach 2 out of the 3. Both patients said they would think about it and call back.

STUDY (Describe the measured results and how they compared to the predictions)

3 calls made, 2 patients reached, no appointments made. Each call took about 5 minutes to complete. Jane had to fit the calls in between patients, and a few times, the flow got backed up waiting for her. The patients were fine with her calling, however none accepted an appointment. Jane liked making the calls but felt harried. Dr. Doe glad it is being worked on.

ACT (Describe what modifications to the plan will be made for the next cycle from what you learned)

Jane and Dr. Doe met and revised what Jane would say and wrote it down. The script includes saying that Dr. Doe requested Jane call and try to assure an appointment is made when the patient says they can make it.　 They decided to run the next test on a Wednesday morning, their slower day and focus on women who need cervical cancer screening. The goal will be to reach 10 patients.

PDSA 17 – Providing Timely Access: Medical assistants (MAs) contact patients to schedule screenings (Cycle 2 of 2)

AIM (overall goal you wish to achieve)
Increasing the number of patients who received needed screening
QUESTIONS:
Will a script that references Dr. Doe and works with the patient on an appointment that will work for them get patients to accept an appointment? Can more calls be made on Wednesday morning and what can we learn about making the process more efficient?

PLAN	
List the tasks needed to set up this test of change	**Person responsible**
On Wednesday 1/16 Jane will call the 10 patients identified by Dr. Doe and use the script they developed. She will work with patients to try and find an appointment time that is convenient for them.	Jane – Medical Assistant (MA) and Dr. Doe

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
A script as above will help patients engage more; making appointments when the patient says she can make it will engage patient more. Questions may come up that Jane cannot answer. The calls will take 5-10 minutes each.	1. How many calls did Jane make? 2. Did something not get done so these calls could get done? 3. How many patients did she reach? 4. How did patients respond to her calling them about this? 5. How many appointments were made? 6. How was it for Jane? Dr. Doe? 7. How much time did it take? 8. What made it successful or barriers?

DO (Describe what actually happened when you ran the test)
On Wednesday Jane was able to call the 10 patients-most in the morning. She identified 5 more to call in the afternoon for a total of 15 calls. She talked with 6 patients, and the script seemed to help them warm up to the idea of coming in. 3 made appointments in the next 3 weeks.

STUDY (Describe the measured results and how they compared to the predictions)
15 calls made, 6 patients reached, 3 appointments made. Each call took longer than the first time, about 10 minutes to complete. Jane had a few chunks of time where she could fit the calls in. She felt more confident after the 3rd call.

ACT (Describe what modifications to the plan will be made for the next cycle from what you learned)
Jane and Dr. Doe want to do a few more rounds of testing-on different days. They want to identify times during the day that Jane could step away from the office flow to make calls. They want to document the steps that seem to work. Once they have that figured out, they will try the test with Dr. Brown and her MA. Dr. Brown wants to try this as well, and she has a newer MA. At some point they will begin tracking if these patients keep their appointment.

PDSA 18 – Providing Timely Access: Using a nurse triage system to expand access to care (Cycle 1 of 2)

Aim (overall goal you wish to achieve)
Expand access to care for recently discharged patients

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done

Plan			
List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
Develop a nurse triage system Assign Jane to nurse triage for one afternoon, using guidelines developed by QI Project Team 1 with John as her provider consultant		.	

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
A nurse triage system will result in patients recently discharged from the hospital being assessed and prioritized into an appropriate appointment type in a timely manner as well as timely appointments for those calling in with acute	Jane will keep track of the number of patients seen, the length of the triage visit, and the reasons for the visits.

Do: (Describe what actually happened when you ran the test)
Jane triaged 5 patients in one afternoon.

Study (Describe the measured results and how they compared to the predictions)
All walk-in patients were appropriately scheduled in the afternoon or evening clinic. The phone call volume was too great for the nurse assigned to triage to handle along with walk-in patients and discharged patients.

Act (Describe what modifications to the plan will be made for the next cycle from what you learned)
Do second PDSA for triage of just those patients who walk-in or are discharged from the hospital. Divert patients calling in to another system/PDSA.

PDSA 19 – Providing Timely Access: Using a nurse triage system to expand access to care (Cycle 2 of 2)

Aim (overall goal you wish to achieve)
Expand access to care for recently discharged patients

Plan			
List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
Jane will try the revised triage system for 1 day Assign Jane to nurse triage for one day, using guidelines developed by QI Project Team 1 with John as her provider consultant. **QUESTIONS** ▪ Will a nurse triage system increase access to care for patients referred by the ED and inpatient discharges and those calling in with acute complaints ▪ Will a nurse triage system increase our efficiency?		.	

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
A nurse triage system will result in patients recently discharged from the hospital being appropriately assessed and prioritized into an appropriate appointment type in a timely manner, as well as timely appointments for those calling in with acute	Jane will keep track of the number of patients seen, the length of the triage visit, and the reasons for the visits.

Do (Describe what actually happened when you ran the test)
Jane tried out the revised triage system on June 12, 2012.

Study (Describe the measured results and how they compared to the predictions)
Jane was able to handle all walk-ins and phone referrals of discharged patients. Triage resulted in MOA's spending fewer minutes (average 10 min) with patients prior to providers seeing the patients. Team determined Jane needs assigned private space close to the clinic and the triage form needs to be revised.

Act (Describe what modifications to the plan will be made for the next cycle from what you learned)
After discussion with all provider teams, this change was instituted, an office switch was made, and the triage form was revised.

PDSA 20 – Providing Timely Access: After-hours coverage survey (Cycle 1 of 1)

PLAN   Pediatric Patient Care Taker Survey on After-Hours Coverage

Objective for this cycle

Evaluate if established Pediatric patients' caretakers are aware we have an after-hours, on-call provider and do they know how to access the on-call provider.

Questions

Do established Pediatric patients' caretakers know we have an after-hours, on-call provider?

If yes, do they know how to access the on-call provider? Can they verbalize this?

Has our communication/education regarding access to care been adequate or is more needed?

Predictions

Some caretakers will know there is an on-call provider and some will not.

Parents/guardians may know there is an on-call provider, but may not know how to access the on-call provider. More targeted education or communication may be needed for our Pediatric population's caretakers.

Plan for change or test: who, what, when, how, where

On 7/23/12, Dr Doe's Medical Assistant will query the caretakers of five (5) scheduled established pediatric patients to see if they are aware of our having an after-hours, on-call provider and how to access the on-call provider.

Plan for collection of data: who, what, when, how, how long

On the date above from 8:15AM-12N, on the 5 scheduled patients for Dr. Doe, the Medical Assistant will ask the parents/guardians two (2) questions after they are triaged in the exam room:

1. Are you aware that we have an after-hours, on-call provider?
2. Do you know how to access the on-call provider? If so, please describe how you can access the on- call provider.

The Medical Assistant will record survey responses on a grid sheet (below) as received from 8:15A-12N and then tabulate results at the end of the query timeframe for provision to Dr. Doe.

As the questions are asked, if there are "no" responses, the Medical Assistant will educate the patient's caretakers. If the questions are answered "no" the Medical Assistant will ask for a "teach-back" response from the caretakers to verbalize how to access the on-call provider. The same request for verbalization will be made for those caretakers who answered "yes" to assure correct information.

DO

Carry out the change or test. Collect data and begin analysis. Describe observations, problems encountered, and special circumstances.

Results: 4 out of 5 selected parents/guardians queried were not aware of an after-hours, on-call provider being available to them; the 1 caretaker who was aware of an after-hours, on-call provider ALSO knew how to access the on-call provider.

	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5
Are you aware that we have an after-hours, on-call provider?	N	N	Y	N	N
Do you know how to access the on-call provider?	N	N	Y	N	N

STUDY

Complete analysis of data. Summarize what was learned. We discovered that 80% (4 out of 5) of our established pediatric patients' caretakers who were tested did not know about availability of the after-hours, on-call provider. After discussion with administration, it was determined that we will add this information to our website, possibly integrate into the patient portal, and post in our pediatric wait room area or front of clinic location (TBD). Additionally, the pediatrician and her Medical Assistant will reinforce after-hours, on-call coverage and protocol with new and established patients at visits.

ACT

Are we ready to make a change? Plan for the next cycle.

After a month has passed from the date of making our after-hours, on-call protocol more visible via web and in clinic, we will repeat this same PDSA to determine if our interventions were successful.

PDSA 21 – Providing Timely Access: Evaluating patient awareness of after-hours call schedule (Cycle 1 of 1)

PLAN

Objective for this cycle

Evaluate if patients are aware we have an after-hours, on-call provider and do patients know how to access the on-call provider.

Questions

Do patients know we have an after-hours, on-call provider?

If yes, do patients know how to access the on-call provider? Can they verbalize this?

Has our patient communication/education regarding access to care been adequate or is more needed?

Predictions

Some patients will know there is an on-call provider and some will not.

Patients may know there is an on-call provider but may not know how to access the on-call provider.

More patient education or communication may be needed.

Plan for change or test: who, what, when, how, where

Thursday June 14th----five scheduled patients for Dr. Doe in the ABC FM clinic -- Jane (nurse) will query the patients see if they are aware of after-hours call provider and how to access the on-call provider.

Plan for collection of data: who, what, when, how, how long

On Thursday June 14th from 7A-12N, on the 5 scheduled patients for Dr. Doe, Jane (nurse) will ask patients 2 questions after they are triaged in the exam room:

1. Are you aware that we have an after-hours, on-call provider?
2. Do you know how to access the on-call provider?

Jane will record patient answers on a grid sheet as received on 6/14 from 7A-12N.

Jane will tabulate results at the end of the query timeframe.

As the questions are asked if there are "no" responses, Jane will educate the patient. If the questions are answered "yes" Jane will ask patient to verbalize how to access the on-call provider.

DO

On 6/14/12 from 7A-12N, Jane asked the questions to 5 patients scheduled for Dr. Doe.

Results: For question 1) 5 no and 0-yes and for question 2) 5 no and 0 yes.

Jane did educate the patients on after-hours, on-call provider and validate how to access.

STUDY

Data results showed that all 5 patients were not aware there is an on-call provider after-hours or how to access. This is concerning as this is an important piece of medical home. If patients are not aware of access to care after-hours are they just going to the ED or possibly postponing care that is needed?

It was identified through this PDSA that we need to do a better job of educating patients on after-hours access. Simply telling them may not be enough—we need to look at options to make this information available to patients in different ways.

Doing this exercise really helped us to think about what we really want to accomplish with this project.

We expected some patients not to know the answers but not all of them.

ACT

Are we ready to make a change? Plan for the next cycle.

Results will be presented to the QI team on 6/26/12 for review, discussion and planning for interventions and next cycle.

Options we have already started to think about are: create screen savers and also put that information on our patient brochure that they are given during check in as well as in the rooms and waiting area.

PDSA 22 – Providing Timely Access: Patient satisfaction surveys (Cycle 1 of 2)

Patient Feedback	**STEP:**	Dissemination of surveys

PLAN

I plan to: We are going to test a process of giving out satisfaction surveys and getting them filled out and back to us.

I hope this produces: We hope to get at least 25 completed surveys per week during this campaign.

Steps to execute:
1. We will display the surveys at the checkout desk.
2. The checkout attendant will encourage the patient to take a survey and an envelope. They will be asked to fill the survey out at home and mail it back to us.
3. We will try this for 2 weeks.

DO

What did you observe?
1. The checkout attendant successfully worked the request of the survey into the checkout procedure.
2. We noticed that the patient had other papers to manage at this time as well.
3. Per checkout attendant, only about 30% actually took a survey and envelope.

STUDY

What did you learn? Did you meet your measurement goal?
We only had 3 surveys returned at the end of 2 weeks. This process did not work well.

ACT

What did you conclude from this cycle?
Some patients did not want to be bothered at this point in the visit – they were more interested in getting checked out and on their way.

Once the patient steps out of the building they will likely not remember to do the survey.

We need to approach them at a different point in their visit when they are still with us – maybe at a point where they are waiting for the doctor and have nothing to do.

PDSA 23 – Providing Timely Access: Patient satisfaction surveys (Cycle 2 of 2)

TOOL: Patient Feedback   **STEP:**   Dissemination of surveys
PLAN
I plan to: We are going to test a process of giving out satisfaction surveys and getting them filled out and back to us. **I hope this produces:** We hope to get at least 25 completed surveys per week during this campaign. **Steps to execute:** 1. We will leave the surveys in the exam room next to a survey box with pens/pencils. 2. We will ask the nurse to point the surveys out/hand then out after vitals and suggest that while they are waiting they could fill out our survey and put it in box. 3. We will see after 1 week how many surveys we collected.
DO
What did you observe? 1. Upon self-report, most nurses reported they were good with pointing out or handing the patient the survey. 2. Some patients may need help reading survey but nurses are too busy to help. 3. On a few occasions the doctor came in while patient filling out survey so survey was not complete.
STUDY
What did you learn? Did you meet your measurement goal? We had 24 surveys in the boxes at the end of 1 week. This process worked better.
ACT
What did you conclude from this cycle? 1. Approaching patients while they are still in the clinic was more successful. 2. Most patients had time while waiting for the doctor to fill out the survey. 3. We need to figure out how to help people who may need help reading the survey.

PDSA 24 – Communicating the care plan: Teach-back method (Cycle 1 of 3)

TOOL: Teach-back **STEP:** MDs performing Teach-back **CYCLE:** 1st Try	

PLAN

I plan to: We will ask the physicians in Wednesday PM to perform teach-back with the last person they see that day.

I hope this produces: We hope that all the physicians will perform teach-back and find that it was useful, did not take that much more time, and they will continue the practice.

Steps to execute:
1. We will ask the 5 physicians who hold clinic on Wednesday PM to perform teach-back with their last patient of the day.
2. We will show these physicians the teach-back video.
3. After their last patient checks out, we will ask the physicians if they felt
   a. it was useful?
   b. it was time consuming?
   c. they will do it again?

DO

What did you observe?
 All physicians found the teach-back video informative and seemed eager to try this new tool.

STUDY

What did you learn? Did you meet your measurement goal?
4 out of 5 physicians performed teach-back on at least one patient in the afternoon. The 1 physician who did not indicated she did not quite know how to integrate it into her visit.

ACT

What did you conclude from this cycle?
4 out of 5 felt comfortable with it and said they would continue using it.

For the 1 who was not sure how to integrate it, we will look for other teach-back resources to help address this.

Ready to introduce to entire clinical staff.

PDSA 25 - Communicating the care plan: Teach-back method (Cycle 2 of 3)

TOOL: Teach-back **STEP:** MDs continuing to perform Teach-back **CYCLE:** modified 2nd try	

PLAN

I plan to: We will see if the physicians in Wednesday PM clinic are still performing teach-back by asking them after their last patient leaves. (3 weeks have gone by since initial introduction.)

I hope this produces: We hope that each of the physicians will have performed teach-back on at least 3 of their afternoon patients.

Steps to execute:
1. We will approach the 5 physicians on Wednesday PM after their last patient leaves and ask them to count the number of patients they performed teach-back on this afternoon.
2. We will ask the physicians if they still feel
   a. it was useful?
   b. it was time consuming?
   c. they will do it again?

DO

What did you observe?
Some physicians could not find appropriate situations for teach-back.
All still felt it was a worthy tool during their patient visits but feel they need to remember it and practice it more.

STUDY

What did you learn? Did you meet your measurement goal?
3 out of 5 physicians said they did perform teach-back on 3 of their patients.
1 performed it in one instance.
1 did not perform it at all (same one as before).

ACT

What did you conclude from this cycle?
Teach-back is being used, maybe not as readily as I had anticipated.
Maybe the goals of '3 out of 6 patient encounters should contain teach-back' is unrealistic. We may put a sign in the clinic rooms, in view of the physicians, to remind them about teach-back.

Will measure again in 6 months.

PDSA 26 – Communicating the care plan: Teach-back method (Cycle 3 of 3)

TOOL: Teach-back   **STEP:** MDs continuing performing Teach-back   **CYCLE:** 3rd Try
PLAN

I plan to
 	
We want to see if the signs put up in the exam rooms help physicians remember to do teach-back and increased its utilization.
 	
I hope this produces We hope that all the physicians will perform teach-back 3 out of 6 times.
 	
Steps to execute
  1. We will put signs reading "Teach it Back" taped on the exam room desk/work area to remind physicians to use the technique.
  2. We will ask physicians if they notice the signs and if they reminded them to perform teach-back.
  3. We will see if Wednesday PM clinic had increased use of teach-back.

DO: What did you observe?
Nurses felt the sign will get in the way.
STUDY: What did you learn? Did you meet your measurement goal?
4 out of 5 physicians did teach-back on 3 patients Wednesday afternoon. 1 did it on 1 patient. 4 out of 5 said they did see the sign and that it was a reminder to do teach-back.
ACT: What did you conclude from this cycle?
That a reminder is needed (especially initially) to help physicians use this tool in their visit. No further intervention needed at this point.

3 | Appendix: Patient Assessed and Care Plan Created

1. Checklists
2. Palliative care questions

Checklist 1 - Nurse/MA Checklist for Post-Hospital Follow-Up Visits

Prior to the Visit:

☐   Telephone Call (ideally within 2 days of discharge):
- Confirm appointment, identify barriers to coming in (e.g., transportation)
- Bring to appointment: medications (all bottles), discharge paperwork
- After-hours care: provide telephone number and instructions

☐   Coordinate with home health care nurses and case managers (if appropriate)

During the Visit, ask the patient to explain:

☐   Goals for the visit

☐   Factors that contributed to hospital admission

☐   Medication reconciliation (with bottles)

☐   Teach back: reasons for taking medications, dose, and frequency

☐   Mobility: Independent or assistance needed

☐   Does patient need additional services at home? (OT/PT/RN/ST)

☐   PHQ 2 completed
- if score is ≥ 3, proceed to PHQ-9 and alert clinician

☐   Provide educational material to guide patient self-management (e.g. HF pamphlets)

At the Conclusion of the Visit

☐   Printed, reconciled medication list provided to patient, family

☐   Care plan changes communicated to patient, family (e.g., new referrals made to HHC)

☐   Next appointment made in timeframe recommended by clinician

☐   After-hours care instructions and telephone number provided

Checklist 2- Provider Checklist for Post-Hospital Follow-Up Visits

Review Prior to the Visit

☐   Discharge summary

☐   Test results need follow-up?

☐   Home Health notes

☐   Nurse/MA checklist

During the Visit

☐   Medication reconciliation

☐   Self-management instruction (teach back)

-        Medications

-        Red flags

☐   Assistance needed at home?

☐   Code status/Palliative care discussion/referral

☐   After-hours care: provide telephone number and instructions

Checklist 3 - COPD checklist: Goals and recommendations

Medications
☐ Oral steroid taper – if current/recent exacerbation
- Has patient filled prescription?
- Does patient understand taper instructions
☐ Short-acting rescue inhaler/nebulizer
- How frequently is patient using?
☐ Long-acting inhaler – Tiotropium or Long Acting Beta-Agonist (Salmeterol or Fometerol)
☐ Steroid inhaler (if $\geq$1 hospitalization/year or $\geq$1 ED visits/year for COPD exacerbation)
☐ Assess adherence and explore/address barriers (e.g., cost)
(missed >1 dose of any medication over the past week?)

Other
☐ Encourage tobacco cessation
☐ Encourage moderate physical activity
☐ Pulmonologist referral, if indicated (e.g., for medication management or diagnostic assistance)
☐ Pulmonary rehabilitation referral, if indicated and patient motivated
☐ Palliative care referral, if indicated (e.g., patient end-stage with severe limitation and symptoms)
- Refer to palliative care checklist

Teach Back
☐ Proper technique for Inhaler use
☐ Symptoms of worsening COPD (e.g., severe shortness of breath, cough)
☐ Actions for symptoms of worsening COPD (protocol for short-acting inhalers/nebs, call MD or 911 if severe shortness of breath)

Checklist 4 - Heart Failure Checklist: Goals and recommendations

Clinical exam
- ☐ Determine volume status (based on weights and symptoms)
- ☐ Adjust diuretic dose as needed

Tests and Medications
- ☐ > 1 echocardiogram completed to assess left ventricular function
- ☐ Left ventricular ejection fraction of <40%?
  If yes, following medications recommended:
  1) ACE inhibitor or ARB
  2) Beta blocker (preferred: Bisoprolol, Carvedilol, or sustained-release Metoprolol)
- ☐ Assess adherence and explore/address barriers (e.g., cost)
  (missed >1 dose of any medication over the past week?)

Other
- ☐ Cardiologist referral, if indicated (e.g., for device such as ICD or CRT; cardiac catheterization)
- ☐ Activity/exercise recommendations
- ☐ Low-salt diet recommendations
- ☐ Daily weight monitoring and recording
- ☐ Cardiac rehabilitation referral, if indicated (ambulatory patients with HF symptoms & reduced LVEF)
- ☐ Palliative care referral, if indicated (e.g., patient end-stage with severe limitation and symptoms)
  - Refer to palliative care checklist

Teach Back
- ☐ Patient's goal weight
- ☐ Low-salt diet (e.g., foods to avoid)
- ☐ Symptoms of volume overload (shortness of breath, weight gain, leg swelling)
- ☐ Actions to take for symptoms of volume overload (limit fluids, take extra diuretics, contact MD)

Checklist 5 - MI checklist: Goals and recommendations

Clinical Exam:
☐   BP <140/90 mm Hg (<130/80 mmHg if CKD)
  - Preferred meds: beta-blockers, ACE, Aldosterone antagonists

Medications:
☐   Aspirin (75 to 162 mg daily)
☐   Beta blocker
☐   Clopidogrel 75 mg/day for coronary stent placed within the past 6 months
☐   Statin (adjust dose if LDL >100)
☐   Assess adherence and explore/address barriers (e.g., cost)
      (missed >1 dose of any medication over the past week?)

Other:
☐   Encourage tobacco cessation
☐   Encourage moderate physical activity
☐   Cardiologist referral, if indicated (e.g., for cardiac catheterization, device placement)
☐   Cardiac rehabilitation referral (eligible if MI, CABG, or PCI in past year)
☐   Left ventricular ejection fraction of <40% - refer to HF checklist

Teach Back:
☐   Symptoms of severe angina or heart attack (e.g., severe shortness of breath, severe chest pain)
☐   Actions for symptoms of a heart attack (take aspirin, nitroglycerin, call 911 if pain severe or persists)

Palliative Care Questions

☐ If you became seriously ill, how sure are you that you would be treated according to your wishes and values?

        Very Sure   Fairly Sure   Not Sure

    Comments:_____

☐ Do you have someone who can make health care decisions for you if you were unable to speak for yourself?

    Comments:_____

☐ Do you have opinions about how you would want to be treated if you had a serious or life-threatening illness?

    Comments:_____

☐ Have you put your opinions in writing?
    Yes   No
    Comments::_____

☐ Is there a symptom(s) that most affects your quality of life or that keeps you from doing what you want to do daily?
    Yes   No
    Comments:_____

☐ How sure are you that you know how to get help if this symptom gets worse?
        Very Sure   Fairly Sure   Not Sure
    Comments:_____

☐ Advanced care planning information given?
    Yes   No
    Comments:_____

☐ Is patient currently enrolled in Hospice?
    Yes   No
    Comments:_____

☐ Is patient currently enrolled in Palliative Care Services?
    Yes   No
    Comments:_____

4 | Appendix: Preparing for the Post-discharge Visit

1. Community referral form template
2. Community referral form example
3. Transitional patient assessment tool

Community Referral Form Template

[Practice Name] **Community Referral Form**

Reason for Referral: _____

    Name of Program: _____

    Name of Contact Person: _____

    Phone: _____

    Location: _____

    _____

    _____

    Details: _____

    _____

    _____

Sample Community Referral Form

Reason for Referral: Improve your reading skills

Name of Program: Adult Reading Program

Name of Contact Person: Melanie Baker

Phone: (555) 555-5555

Location: Spencer Adult Leaning Center

560 Blake Lane

Fauxcity, FS, 55555

Details: Free reading classes

Call Melanie or stop by to sign up

Transitional Patient Assessment Tool
TPAT

To be completed by Hospital Liaison. **TC priority___ CCNC priority__Palliative Care ____**

Name: _____ Phone Numbers: _____

Admit Date: _____ Discharge Date: _____ Days in Hospital: _____

Contact person: _____Relation: _____ Phone: _____

DIAGNOSIS:

Reason for hospital stay:_____

SOCIAL:

Do you read and write? ____yes ____No

Live alone:___ Lives with:_____

need assistance with ADL's___, Caregiver for someone else___ Been in the hospital in the last month____, Not applicable____

Who provides transportation: _____

Any problems with medications? Affording___, picking them up____, getting refills____, taking them____, Other_____ Not applicable_____

Prescriptions filled at: _____Phone:_____

When discharged, will be going where: _____ Phone: _____

Comments; _____

FOLLOW UP APPOINTMENTS:

Primary Care Doctor: _____ Phone: _____

ASSISTANCE AT HOME:

Home Health:_____Phone:_____

PCS/CAP:_____Phone:_____

Greatest concerns about going home from the hospital:_____

_____

_____

_____

_____H

Hospital Liaison Signature: NAME   DATE

Transitional Patient Assessment Tool
TPAT

To be completed by primary care manager during home visit/face to face visit:

WARNING SIGNS:

I will call _____ at _____ if I have any of the following signs:

1)	4)
2)	5)
3)	6)

Goals related to my care:

Goal	by date	My responsibility

Leave copy of form with the client

I understand my treatment plan. I feel able and willing to participate actively in my care.

Patient Signature: _____ Date: _____

Nurse Care Manager Signature: _____ Date: _____

If you have ANY problems or questions about your health after leaving the hospital, please call your doctor listed above. PLEASE BRING ALL OF YOU MEDICINES AND DISCHARGE PAPERS TO YOUR FOLLOW-UP APPOINTMENTS.

5 | Appendix: Care Plan Communicated

1. Teach-Back Self-Evaluation and Tracking Log

Teach-Back Self-Evaluation and Tracking Log

Name: _____ **Start/end date:_____/_____**

Patient ID	# Items to do or remember	Teach-back used?		Results – Clarification needed? Patient perceptions? Your assessment?	What to do differently next time
		Yes	*No*		
	1. Increase evening insulin dose to 26 units. 2. Start Enalapril 5 mg, take 1 pill every morning.	X		*I asked the patient to tell me his medication changes. He understood the addition of Enalapril and the dose, but he forgot how much I asked him to increase his insulin dose by. I clarified, and he actually expressed his appreciation for my confirmation.*	*If I find that many patients can't recall their medication changes, I may use a form to write them down for all patients.*

6 | Appendix: Measures

30-Day All-Cause Readmissions (Unadjusted)

Measure: Percent of patients readmitted to hospital for any cause within 30 days of discharge (Unadjusted)

Target: 20% relative reduction from baseline rate within 12 months

Source: IHI STAAR Initiative's *How-to Guide: Improving Transitions from the Hospital to Post-Acute Care Settings to Reduce Avoidable Rehospitalizations*[1]

Population: Ideally, your practice measures readmissions for your entire patient population. Practically, you may have data for only a subset of your practice's patient population. You may begin measuring readmissions for a subset of your practice's patient population and add other segments of the population over time as data is available.

Calculation:

$$\frac{\text{\# of patients admitted to any hospital for any cause within 30 days of discharge}}{\text{\# of patients admitted to hospital}} \quad X \ 100 \quad = \quad \text{Percent of all-cause readmissions}$$

Exclusions:
- 23-hour observations
- Transfers to another acute care hospital
- Discharges to psychiatric facilities, rehab facilities, long-term care hospitals, hospice
- Patients who die before discharge
- Patients discharged against medical advice

Interval: Monthly on a rolling basis

Example:
- To measure & report readmissions, you need dates of admission and discharge. A readmission is, by definition, tied to an index discharge. For reporting purposes, a readmission is counted for the month in which the index discharge occurred.
- March's readmission rate reflects discharges that occurred mostly in March followed by an admission in April. See C. Taylor example below for an exception.
- April's readmission rate reflects discharges that occurred in April followed by an admission in May.
- Assume you want August to be the first month you report readmissions. A report reflecting August readmissions will not be available until Sept 30 at the earliest. To report readmissions for August, you need discharge dates from August and admissions dates in September.
- If you just want to start measuring in August, the first month you can report on is Sept.

Patient	Discharge Date	Admissions Date	# of Days	Counted as Readmission?	For what month?
C. Taylor	3/1/2012	3/31/2012	30	Yes	Mar 2012
C. Baker	3/14/2012	4/12/2012	28	Yes	Mar 2012
S. Walker	3/18/2012	5/13/2012	55	No	
M. Haynes	4/1/2012	4/14/2012	13	Yes	Apr 2012
L. Casper	4/30/2012	5/28/2012	29	Yes	Apr 2012
M. Smith	6/24/2012	None as of 7/3/12			

Discharge Summary Available at Follow-up Appointment

Measure: Percent of first post-hospital completed appointments when the provider had the discharge summary (**not** discharge instructions provided to patient) available at the time of the appointment.

Target: 90%

Source: IHI STAAR Initiative's *How-to Guide: Improving Transitions from the Hospital to Post-Acute Care Settings to Reduce Avoidable Rehospitalizations*1

Population: Ideally, your practice measures availability of discharge summary for your entire patient population. You may begin measuring availability of discharge summary for a subset of your practice's patient population and add other segments of the population over time.

Calculation:

$$\frac{\text{\# of completed, first post-discharge appointments when the provider had the discharge summary at the time of the appointment}}{\text{\# of completed, first post-discharge appointments}} \times 100 = \text{Percent of completed, first post-discharge hospital appointments when the provider had the discharge summary at the time of the appointment}$$

Exclusions: **none**

Interval: Monthly; evaluate measure at end of each month

High and Moderate Risk Patients Seen within Five Days of Discharge

Measure: Percent of high and moderate risk patients who are seen within five days of discharge

Target: 80%

Population: Ideally, your practice measures timely access to care following a hospitalization for your entire patient population. You may begin measuring timely access to care following a hospitalization for a subset of your practice's patient population and add other segments of the population over time.

Calculation:

$$\frac{\text{# of patients at high and moderate risk for readmission who complete an appointment within 5 days of hospital discharge}}{\text{# of patients at high and moderate risk for readmission}} \times 100 = \text{Percent of patients at high and moderate risk for readmission who are seen within five days of discharge}$$

Exclusions:
- Appointment rescheduled by patient
- Patient readmitted prior to follow-up appointment (i.e. follow up appointment scheduled within 5 days, but readmission prior to appointment)

Interval: Monthly; evaluate measure at end of each month

Patient	Discharge Date	High or Moderate Risk?	Target f/u Appointment Date	Date of Completed Appointment	# of Days	Met Target?	For what month?
C. Taylor	3/1/2012	Yes	3/6/2012	3/8/2012	2	Yes	Mar 2012
C. Baker	3/14/2012	No				n/a	
S. Walker	3/18/2012	No				n/a	
M. Haynes	4/1/2012	Yes	4/6/2012	4/14/2012	8	No	Apr 2012
L. Casper	4/30/2012	Yes	5/5/2012	5/8/2012	3	Yes	Apr 2012
M.Smith	6/24/2012	No					

Timely Hospital Discharge Notification

Measure: Percent of discharges practice is notified of within 24 hours of discharge

Target: 80%

Population: Ideally your practice measures availability of discharge data for your entire patient population. You may begin measuring availability of discharge data on a subset of your practice's patient population and add other segments of the population over time. Examples of subsets include: one hospital, one payer, one clinical condition, etc.

Calculation:

$$\frac{\text{\# of hospital discharges practice is notified of within 24 hours of discharge}}{\text{\# of hospital discharges}} \times 100 = \text{Percent of discharges practices is notified of within 24 hours of discharge}$$

Interval: Monthly; evaluate measure at end of each month

7 | Appendix: Case Studies

Case Study 1: Communicating with hospital

Problem: The regional hospital did not consistently notify the practice of hospitalized patients or fax discharge summaries to the practice. This made it difficult to plan for timely follow-up visits or to assure continuity of care.

Aim: To address this problem, the practice decided to create a system to assure communication with the regional hospital—making sure the hospital would notify the practice of currently hospitalized or discharged patients.

Method: Practice created a multi-departmental team to conduct internal workflow and systems assessment relevant to communication exchanges with the regional hospital using a transitions assessment tool. Practice protocol and policy "Transition of hospitalized and emergency room patients" were written, reviewed and approved by the team and shared with staff. The medical director, AHEC, and CCNC QI Coordinator on the project met with Regional Hospital's key emergency department and hospital administrative and physician leads to review concerns related to need for improved communications and to share new practice protocol and policy.

Results: The practice completed training and gained access to Regional Hospital's new EHR. They piloted with *the regional Health Information Exchange* to have discharge summaries "pushed" to practice users for integration into practice EHR.

Practice take away: It is critical to conduct a practice assessment to identify gaps, barriers and concerns related to patient care and treatment in order to develop an effective care transitions strategy. Once referral sources and partner providers (hospitals, specialists, EDs) are identified, collaborative dialogue needs to occur to address key information exchange between and among parties. Policies and procedures should be formalized and shared with community partners and practice staff.

Case Study 2: Educating patients about after-hours access

Problem: Based on a practice-based survey, we learned that our patients were not aware that the practice had after-hours telephone access to a provider.

Aim: The practice planned to increase patients' knowledge and understanding of how to access their medical home provider after-hours.

Method: The practice took several steps to educate the patient and to utilize available data to understand patient ED use. First, the practice posted colorful medical home/emergency department (ED) diversion posters (in English and Spanish languages) in patient waiting areas. Practice medical assistants and providers described appropriate reasons to contact the on-call physician (i.e., not for medication refills or to schedule appointments) and how to use the practice for sick visits instead using of the ED.

To better understand what was driving ED utilization, the practice used the CCNC provider portal to identify Medicaid ED utilization both during and after-hours. The practice partnered with the CCNC care manager to assure that discharge summaries were available prior to or at the time of the patient's first ED/hospital discharge follow-up visit. CCNC's care manager helped coordinate and was able to attend 100% of the practice follow-up visits for these recently discharged patients.

Results: Currently, the physician on call is available 24-7 by telephone contact for advice. He/she sends "voice notes" to a secure practice e-mail, and the practice staff reviews the notes next day to plan appropriate follow-up. The practice is working toward electronically integrating these notations into the EHR, but currently has to manually transcribe them into patient's EHR records.

Practice Take-away: ED utilization occurring during the business hours of the practice was surprising. It is important not to overlook the simplest things that may improve patient behaviors and quality of care such as emphasizing after-hours accessibility and educating about appropriate use of ED. Partnering with the CCNC care manager facilitates getting the recently discharged patients into the practice and assuring availability of the discharge summaries prior to or at time of visit.

Case Study 3: Educating patients about after-hours access

Problem: Patients did not realize the hospital-owned practice has on-call providers available after office hours.

Aim: The practice planned to educate patients about hospital's on-call providers for primary care.

Method: To help educate their patients, the practice developed and distributed a flyer to patients who came in for post-hospital appointments. The flyer informed them about on-call providers and how to reach on-call provider after-hours. The practice also designed and displayed a poster in the front office to inform patients about on-call providers and process. The poster was placed on easel in waiting area. Clinic staff used the teach-back method at discharge to ensure the patients understood how to reach the practice after-hours.

Results: From January to April of 2013, the practice had no readmissions. The hospital-owned practices also implemented an EMR during the project time period, which allowed hospital providers who were on call for practices to access patient records for better continuity.

Practice take-away: The practice found patients were eager to learn that they could access care after-hours other than hospital ED.

Case Study 4: Identifying high-risk patients for follow-up

Problem: ABC Family Medicine, a hospital-owned practice, had no process in place to share information with ABC Hospital staff that would identify their high-risk patients who needed primary care provider follow-up within 2-5 days of discharge.

Aim: ABC Family Medicine's goal was to get the hospital staff to identify the practice's designated high-risk patients and proactively schedule these patients for follow-up visits within 2-5 days of discharge.

Method: The CCNC facilitator, attending physician, and process analyst reviewed the EMR with the floor nursing managers to identify where in the EMR the doctor could identify patients as high risk. They utilized a risk stratification tool that included number of medications and recent ED/inpatient hospitalizations. Once the patient was identified, this allowed the patient to be scheduled in a timely manner for a high-risk follow-up appointment. The practice registration staff (who routinely schedule the follow-up visits) were also made aware to expect these calls from the hospital staff. The high-risk follow-up slots were set up and held for these patients.

Results: In the past the ABC Hospital medical interns had to call ABC Family Medicine and ask for clinic appointments for all the impending discharge patients. This was very time consuming and not a role for an intern.   Now, the clinic is moving toward having 1-2 "high-risk follow-up" slots available every day that could accommodate any ABC Family Medicine hospitalized patient who is considered at risk.

Practice take-away: Access for these high-risk patients is crucial in order to prevent readmissions. The high-risk slots need to be "carved out" for patient success.

Case Study 5: Integration of clinical pharmacist into hospital follow-up visits

Problem: The previous clinical pharmacist was not routinely part of hospital follow-up visits. The position was vacant, but a new hire was coming on board.

Aim: Since medication reconciliation is a major part of care transitions, we wanted to integrate the clinical pharmacist into our hospital follow-up visit standard protocol for high-risk patients starting August 1, 2013.

Method: The practice changed the Transitional Care Process map to include the clinical pharmacist. Schedulers made appointment with the clinical pharmacist and the provider within the high-risk timeframe (coordinating times). The clinical pharmacist took the primary role with medication reconciliation. The practice revised their hospital follow-up protocol to include the following clinical pharmacist tasks:

- Goals for the visit
- Factors that contributed to hospital admission
- Medication reconciliation (with bottles)
- Teach back: reasons for taking medications, dose, and frequency

Results: Integrating the clinical pharmacist into the follow-up visits has been successful. As of June 30, 2013, 100% of patients with hospital follow-up visits had medication reconciliation done and brought their medications in with them.

Practice take-away: Always ask—who is the best person to do this? And, periodically, revisit processes, roles and responsibilities.

Case Study 6: Medication Reconciliation

Problem: The practice had no way to track medication reconciliation and whether medications were brought in to follow-up visits.

Medication reconciliation is a key component of the care transition assessment and care planning. Bringing in medications provides the opportunity for the health care team, using motivational interviewing and teach back, to assess and verify that patients are taking the correct medications and why.

Aim: The practice hoped to implement medication reconciliation tracking (that includes bringing in medications) for hospital follow-up visits within 30 days (April 1, 2013). The goal was: by June 30, 2013 that 75% of hospital follow-up visits would have medication reconciliation included and performed.

Method: To reach their aim, the practice:
1) Developed and tested an Excel tracking log.
2) Added new communication/education to automated script reminder calls asking patients to bring in all medications—this includes a confirmation report.
3) Created practice policy for reminder calls. When nurses call patients/families to remind them of hospital/ED follow-up visits, they also remind them to bring in all their medications.
4) Received instruction on 1) the importance of medication reconciliation, which should include patient medications being brought in; and 2) the use of teach back and motivational interviewing to assess and verify patients are taking the correct medications and why.
5) Added medication reconciliation as part of the Quicktext checklist in the EHR for nursing and providers for hospital follow-up visits.

Results: The practice reviews the Excel tracking log every day, and it is working well. As of June 30, 2013, 100% of patients with hospital follow-up visits had medication reconciliation done and brought medications in with them. The Quicktext checklist in the EHR serves as a reminder that this is part of standardized protocol for a hospital or ED follow-up visit. Patients and their families have communicated that the reminder calls and attention to medications is very helpful.

Practice Take-away: It is important to make medication reconciliation part of your routine. Use the checklist as a helpful reminder. It takes time and persistence to get patients to bring in their medications. They need to know it is important to the practice so we need to keep communicating this to them.

8 | Appendix: Helpful Links

We refer to a number of other tools, documents, and websites in this document. Below is a table of links for quick reference to external sources and examples on quality improvement and care transitions. Most are also embedded throughout this document.

Additional Resources

✦ IMPACT Care Transitions Collaborative Webinars

Getting Started
✦ Quality Improvement Methods
   ✦ IHI How to Improve
   ✦ IHI Testing Changes
✦ AAFP Risk-Stratified Care Management and Coordination Table
✦ Using a Driver diagram http://tipqc.org/qi/jit/tools/driver-diagram/
✦ Choosing a process to work on http://tipqc.org/qi/jit/methods/choosing-a-process-to-work-on/

Providing Timely Access to Care
✦ Safety Net Guide to Expanding Access
✦ Open Access Management Team Implementation Toolkit

Preparing for a Post-Discharge Visit
✦ CCNC Care Management
✦ Safety Net Medical Home Initiative—Care Coordination
✦ Information and Referral Search (211)
✦ CWF Linking with Your Community
✦ How to Link Patients to Non-Medical Support

Communicating the Care Plan
✦ How to Implement "Teach Back" Method
✦ The Teach Back Method Video
✦ Health Literacy Universal Precautions Toolkit

References

[1] Schall M, Coleman E, Rutherford P, Taylor J. *How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations.* Cambridge, MA: institute for Healthcare Improvement; June 2011. Available at www.IHI.org.

[2] Fazzi R, Agoglia R, Mazza G, Glading-DiLorenzo J. The Briggs National Quality Improvement/Hospitalization Reduction Study. Caring: National Association for Home Care magazine. 2006;25(2):70.

[3] Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

[4] Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *New England Journal of Medicine*. 2009 Apr 2;360(14):1418-1428.

[5] Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA*. Feb 282007; 297(8):831-841.

[6] American Academy of Family Practice: A Family Practice Management blog. Tuesday Feb 12, 2013 Decoding the new transitional care management rules and THURSDAY NOV 29, 2012 CMS approves new codes for Transitional Care Management.

[7] Neal R, Moore LG, Powell J. Enhanced Access: Providing the Care Patients Need, When They Need It. In: Phillips KE, Weir V, eds. Safety Net Medical Home Initiative Implementation Guide Series. 2nd ed. Seattle, WA: Qualis Health and The MacColl Center for Health Care Innovation at the Group Health Research Institute; 2013.

[8] Auger KA, Kahn RS, Davis MM, Beck AF, Simmons JM. Medical Home Quality and Readmission Risk for Children Hospitalized With Asthma Exacerbations. *Pediatrics* 2013;131:64-70.

[9] Lawlor M, Sinead Kealy S, Agnew M, Korn B, Quinn J, Cassidy C, Silke B, O'Connell F, O'Donnell R. Early discharge care with ongoing follow-up support may reduce hospital readmissions in COPD. *Int J Chron Obstruct Pulm Dis* 2009;4:55-60.

[10] Improving Care Transitions: Optimizing Medication Reconciliation. ASHP APhA, March 2012.

[11] Karapinar-Çarkıt F, Borgsteede SD, Zoer J, Smit HJ, Egberts ACG, van den Bemt PMLA. Effect of Medication Reconciliation With and Without Patient Counseling on the Number of Pharmaceutical Interventions Among Patients Discharged from the Hospital. *Ann Pharmacother 2009;43:1001-10.*

[12] DeWalt DA, Callahan LF, Hawk VH, Broucksou KA, Hink A, Rudd R, Brach C. Health Literacy Universal Precautions Toolkit. (Prepared by North Carolina Network Consortium, The Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill, under Contract No. HHSA290200710014.) AHRQ Publication No. 10-0046-EF) Rockville, MD. Agency for Healthcare Research and Quality. April 2010.