PROVIDER TRAINING

REVIEW OF INSTITUTE FOR HEALTH IMPROVEMENT REDUCING OF AVOIDABLE REHOSPITALIZATIONS MATERIALS

June 26, 2012

Southeast Texas Medical Associates, LLP

Outline of Presentation

- **Slides 3 – 85**
  - A review of the four leverage points of IHI's Transitions of Care for Reducing Rehospitalizations
- **Slides 86 – 92**
  - SETMA's tools for fulfilling IHI's Transitions of Care for Reducing Rehospitalizations
- **Slides 93 – 101**
  - SETMA's Points of Leverage

Introduction

- The slides which are direct quotes from the IHI document are noted as "**(IHI)**". Quotation marks are not used for convenience in this "not-for-publication," in-house presentation.

- Slides that do not have that designation are either conclusions based on the IHI work, or a part of SETMA's experience.

IHI How-To Guides

- IHI also provides additional How-to Guides for:
  - *How-to Guide: Improving Transitions from the **Hospital to Post-Acute Care Settings** to Reduce Avoidable Rehospitalizations*
  - *How-to Guide: Improving Transitions from the **Hospital to Skilled Nursing Facilities** to Reduce Avoidable Rehospitalizations*
  - *How-to Guide: Improving Transitions from the **Hospital to Home Health Care** to Reduce Avoidable Rehospitalizations (IHI)*

Summary of SETMA's Performance on IHI Standards

During SETMA's Provider Training in July, August and September, 2012, we will review each of these in turn. At the end of this process, we will have a good understanding of the processes of rehospitalizations.

As we go through the IHI document, I believe, everyone will be pleased that we had already identified the areas of maximum leverage for addressing rehospitalizations detailed by IHI.

We have much to learn but we have also learned much. We have much to do but we have also done much.

With pride in what we have done and with a relentless commitment to excellence, we move forward.

Introduction

- ***Improving Transitions from the Hospital to The Clinical Office Practice to Reduce Avoidable Rehospitalizations***

- Reference: 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 2012. Available at www.IHI.org.

Reducing Rehospitalizations

- Poor coordination of care across settings too often results in rehospitalizations, many of which are avoidable. Importantly, working to reduce avoidable rehospitalizations is one tangible step toward achieving broader delivery system transformation.(IHI)

- Care Coordination and preventable readmissions are closely linked in national studies, initiatives and in SETMA's experience.

Reducing Rehospitalizations

- Hospitalizations account for nearly one third of the total $2 trillion spent on health care in the United States. In the majority of cases, hospitalization is necessary and appropriate…experts estimate that 20 percent of US hospitalizations are rehospitalizations within 30 days of discharge. (IHI)

Avoidable Rehospitalizations

- According to an analysis conducted by the Medicare Payment Advisory Committee (MedPAC), up to 76 percent of rehospitalizations occurring within 30 days in the Medicare population are potentially avoidable. (IHI)

- Avoidable hospitalizations and rehospitalizations are frequent, potentially harmful, and expensive, and represent a significant area of waste and inefficiency in the current delivery system. (IHI)

Avoidable Rehospitalizations

- It may be possible to reduce the total readmission of a Medicare Population by 15.2% of the current 20%, making the effective readmission rate 4.8%.

Avoidable Rehospitalizations

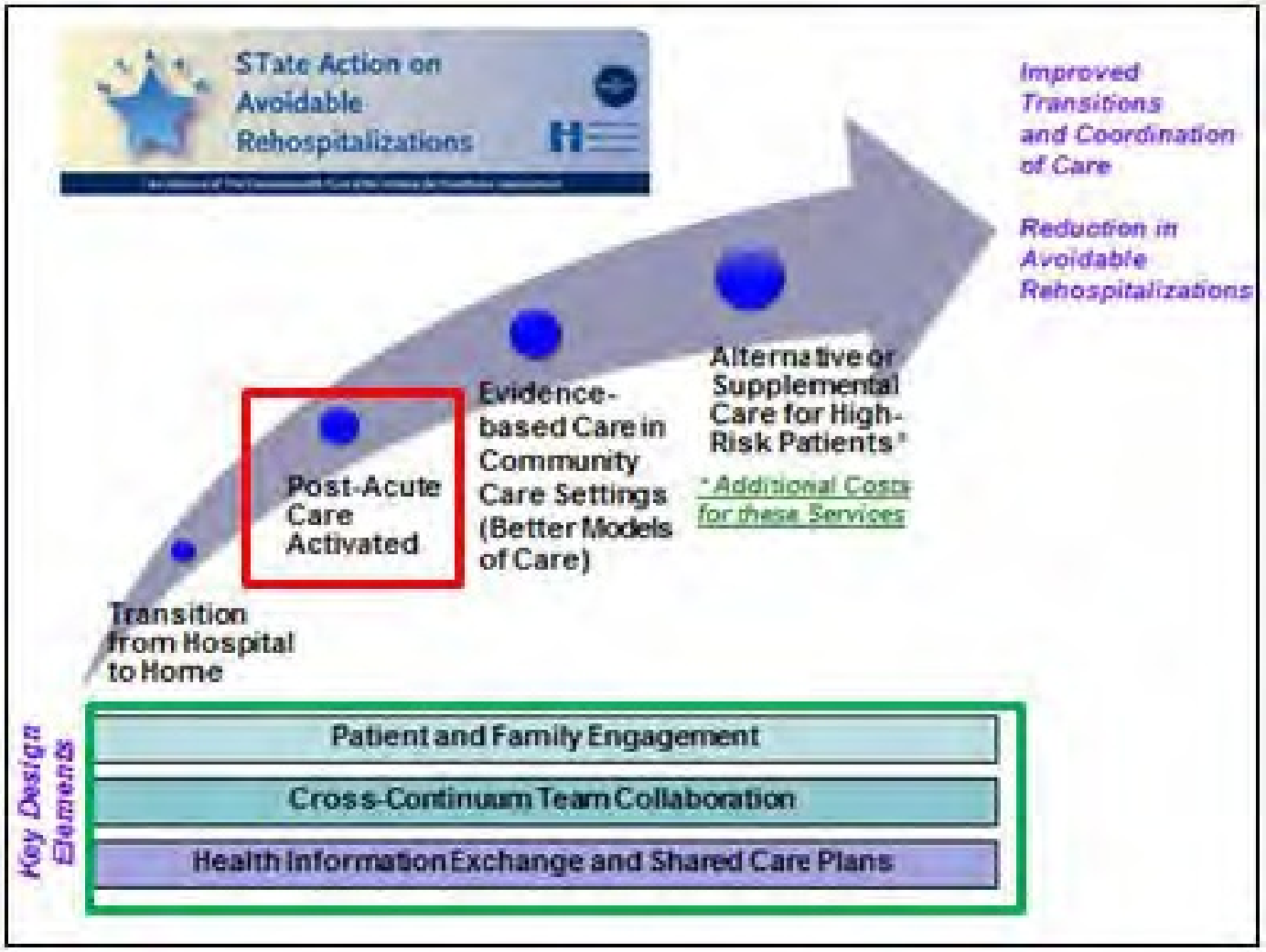
- Research shows that one-quarter to one-third of these patients return to the hospital due to complications that could have been prevented. (IHI)

- Unplanned rehospitalizations may signal a failure in:
  - hospital discharge processes,
  - patients' ability to manage self-care, and/or
  - the quality of care in the next community setting (such as office practices, home health care, and skilled nursing facilities). (IHI)

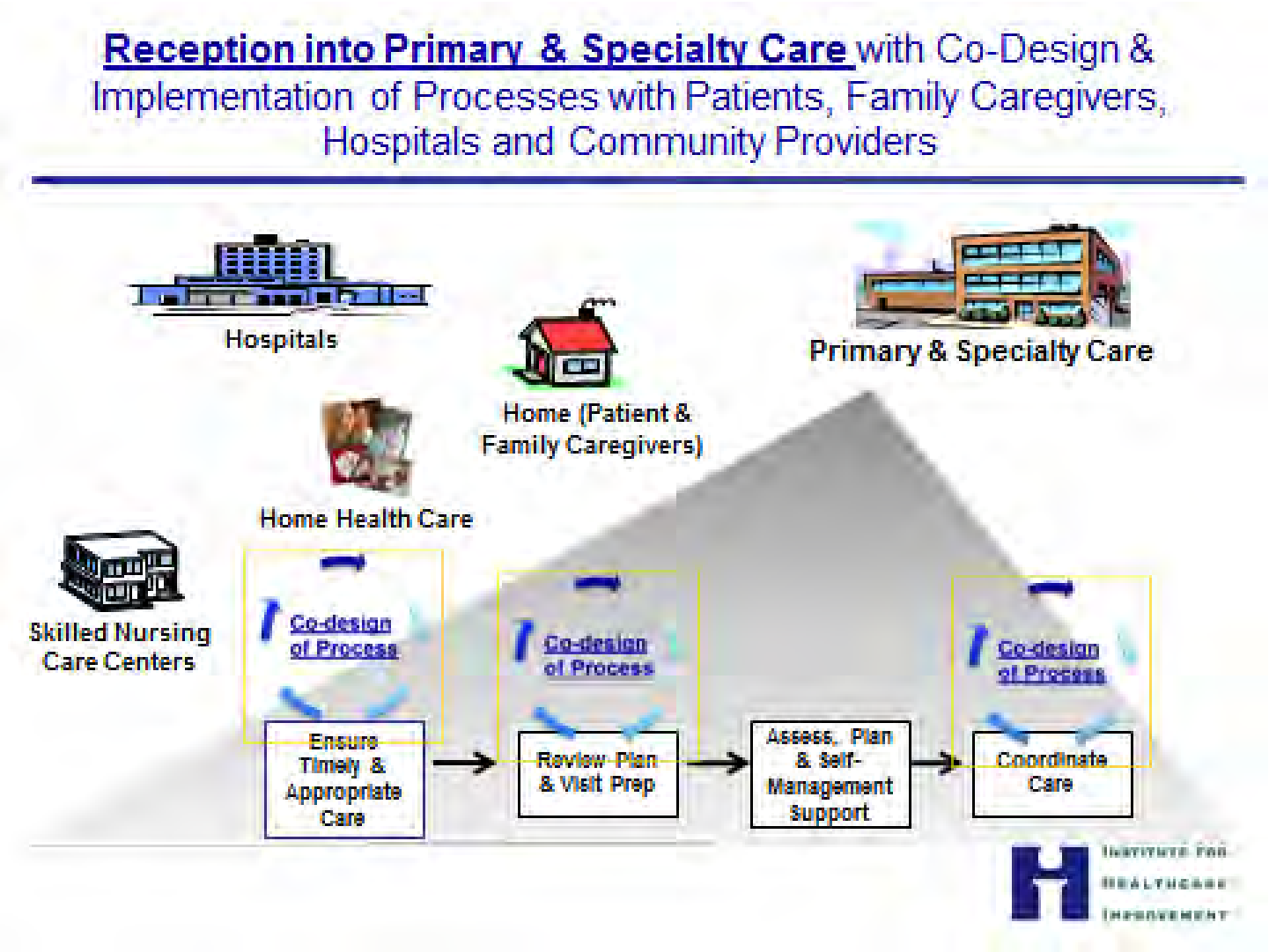
Reducing Rehospitalizations

- Patients are especially vulnerable to adverse events in the period immediately following discharge, and **they need immediate access to a trusted clinician** who can answer questions, provide advice, and help ensure that their clinical condition remains stable. (IHI)
- Too often, patients find themselves on their own after discharge, struggling to manage their medications, monitor their conditions, and follow instructions received at the hospital. (IHI)
- Immediate post-discharge contact with providers is crucial for preventing an avoidable readmission, especially among patients with multiple conditions or complicated medication and treatment plans, and those with limited capacity for self-care or access to family or community support. (IHI)

IHI's Roadmap for Improving Transitions in Care After Hospitalization and Reducing Avoidable Rehospitalizations (IHI)



Process Changes to Achieve an Ideal Transition from Hospital to the Clinical Office Practice (IHI)



Creating an Ideal Transition to the Clinical Office Practice (IHI)

- Four recommended changes for improving the transition for the patient from the hospital to the clinical office practice setting by mitigating the typical failures or problem areas associated with this transition"
  1. Provide **timely access** to care following a hospitalization;
  2. **Prior to the visit,** prepare the patient and the clinical team;
  3. **During the visit,** assess the patient and initiate a new care plan or revise an existing care plan; and
  4. At the **conclusion of the visit,** communicate and coordinate the ongoing care plan. (IHI)

1. Timely Access To Care

1. **Provide Timely Access to Care Following a Hospitalization**

    A. Review on a daily basis information received from the hospital about admissions and anticipated discharges.

    B. Provide appropriate level and type of follow-up for high-risk, moderate-risk, and low- risk discharged patients. (IHI)

2. Prior To The Visit

2. **Prior to the Visit: Prepare Patient and Clinical Team**

    A. Review the discharge summary.
    B. Clarify outstanding questions with sending physician(s).
    C. Place a reminder call to patient or family caregiver to help them prepare for the visit.
    D. Coordinate care with home health care nurses and case managers if appropriate. (IHI)

3. During The Visit

3. **During the Visit: Assess Patient and Initiate New Care Plan or Revise Existing Plan**

   A. Ask the patient about his/her goals for the visit, what factors contributed to hospital admission or ED visit, and what medications he/she is taking and on what schedule.

   B. Perform medication reconciliation with attention to the pre-hospital regimen.

   C. Determine need to adjust medications or dosages, follow up on test results, do monitoring or testing; discuss advance directives; discuss specific future treatments.

3. During The Visit

3. **During the Visit: Assess Patient and Initiate New Care Plan or Revise Existing Plan**

    A. Instruct patient in self-management; have patient repeat back.

    B. Explain warning signs and how to respond; have patient repeat back.

    C. Provide instructions for seeking emergency and non-emergency after-hours care. (IHI)

4. At The Conclusion Of The Visit

4. **At the Conclusion of the Visit: Communicate and Coordinate Ongoing Care Plan**

   A. Print reconciled, dated medication list and provide a copy to the patient, family, home health care nurse, and case manager, if appropriate.

   B. Communicate revisions of the care plan to the patient, family caregiver, home health care nurse, and case manager, if appropriate.

   C. Ensure that the next appointment is made, as appropriate. (IHI)

1. Timely Access To Care

Recommended Changes:

- Provide timely access to care following a hospitalization.
- Review on a daily basis information received from the hospital about admissions and anticipated discharges.
- Provide appropriate level and type of follow-up for high-risk, moderate-risk, and low-risk discharged patients. (IHI)

1. Timely Access To Care

Nine Typical Failures

1. Primary or specialty care physician does not know his or her patient has been admitted or discharged because of the lack of an alert system from hospital to office;
2. Hospital physicians cannot easily reach the office practice physicians because the outpatient physicians are busy with patients in the office or have difficulties with phone access and leaving messages;
3. Lack of person-to-person contact between hospital and office practice staff is caused by an absence of identified individuals to coordinate communication on each end;

1. Timely Access To Care

Nine Typical Failures

4. Patient is told to schedule an appointment with his or her primary or specialty care provider, but is confused about whom he or she should see, by when, and why;
5. Knowledge gap for those patients whose condition rapidly deteriorates with respect to whom to contact for help.
6. Lack of agreement and clarity about whether hospital or office practice staff are responsible for providing post-discharge phone contact and scheduling home health care services;

1. Timely Access To Care

Nine Typical Failures

7. Lack of open appointments in the office practice schedule for post-discharge visits within 48 hours;
8. Information from the primary care physician (i.e., feed forward) about a newly admitted patient is often unavailable to the hospital staff doing the initial admission assessment and medication reconciliation;
9. Patient discharge information is not standardized with respect to data elements, format, and mode of transmission; each physician may provide different information about the patient at discharge. (IHI)

Diagnostic Worksheet - 1

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, 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?

Diagnostic Worksheet - 2

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 care 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.

Check List – Post-Hospital Follow-Up Visits

Checklist for Post-Hospital Follow-Up Visits

Prior to the Visit

- ☐ Review discharge summary.
- ☐ Clarify outstanding questions with sending physician.
- ☐ Reminder call to patient or family caregiver to:
  - ☐ Stress importance of the visit and address any barriers.
  - ☐ Remind to bring medication lists and all prescribed and over-the-counter preparations.
  - ☐ Provide instructions for seeking emergency and non-emergency after-hours care.
- ☐ Coordinate care with home health care nurses and case managers if appropriate.

During the Visit

- ☐ Ask the patient to explain:
  - ☐ His/her goals for visit.
  - ☐ What factors contributed to hospital admission or ED visit.
  - ☐ What medications he/she is taking and on what schedule.
- ☐ Perform medication reconciliation with attention to the pre-hospital regimen.
- ☐ Determine the need to:
  - ☐ Adjust medications or dosages;
  - ☐ Follow up on test results;
  - ☐ Do monitoring or testing;
  - ☐ Discuss advance directives;
  - ☐ Discuss specific future treatments (POLST).
- ☐ Instruct patient in self-management; have patient repeat back.
- ☐ Explain warning signs and how to respond; have patient repeat back.
- ☐ Provide instructions for seeking emergency and non-emergency after-hours care.

At the Conclusion of the Visit

- ☐ Print reconciled, dated, medication list and provide a copy to the patient, family caregiver, home health care nurse, and case manager (if appropriate).
- ☐ Communicate revisions to the care plan to family caregivers, health care nurses, and case managers (if appropriate). Consider skilled home health care or other supportive services.
- ☐ Ensure that the next appointment is made, as appropriate.

Laying the Foundation

- We recommend that office practices lay the foundation for optimal patient follow-up by:

1. Jointly designing the discharge summary document with hospital and emergency department physicians
2. Creating capacity in their clinic schedules to anticipate the need for post-discharge appointments. (IHI)

Joint Design

- The primary care practice and the hospitalists and/or other hospital-based clinicians should agree on the content of information about the patient that needs to be shared, the format of the document, and the preferred methods for communication.
- The communication system should be designed as a two-way system so that information from the practice to the hospital can occur upon admission and as needed throughout the hospital stay (e.g., medications, prior treatment plans, social support information, etc.) and from the hospital to the practice upon admission, throughout the hospitalization (as needed), and at discharge. (IHI)

Joint Design

- The following elements can be included in the agreement or protocol between the two parties:
  1. The timing of communication concerning admission and discharge
  2. How the information will be sent or transmitted (e.g., fax, cell phone, secure e-mail, pager, directly from information system)
  3. Who is responsible for scheduling the post-hospital follow-up visit
  4. What specific information will be included by each party on admission, during hospitalization, and upon discharge in the hospital discharge summary or ED visit summary
- Practice and hospital clinicians and/or care-team members may wish to visit each other's locations as a way to share information about their respective processes and to clarify and refine any communication issues. (IHI)

1. Creating Access

- To provide timely access to care following a hospitalization, providers in an office practice must anticipate the needs of each patient and have capacity in their clinic schedules for the appropriate level of contact.
- Practices can use a number of strategies for creating capacity in their clinic schedules to anticipate the need for post-discharge appointments. Practices with advanced clinic access systems have open appointment slots each day in their scheduling system to meet the same- day needs of all their patients, including those recently discharge from the hospital. Information on advanced access systems is available at (IHI)

1. Creating Access

Making Changes

Once the practice has systematized communications and ensured its ability to schedule patients for follow-up visits, it can then design an optimal system for:

1. actually providing timely and appropriate care following a hospitalization, and
2. coordinating with other clinicians and support services for ongoing care. (IHI)

Making Changes in Access

Review on a daily basis information received from the hospital about admissions and anticipated discharges.

1. Check electronic transmission of information from the hospital or initiate daily contact with a designated hospital contact to obtain and act on information about hospitalized patients;
2. Contact the designated hospital contact person to **(a)** clarify any information about patients' clinical status and needs at discharge, especially patients at high or moderate risk for readmission; and **(b)** provide any additional information that might be needed about the patient to the hospitalist or hospital-based clinicians; and

Making Changes in Access

- Include the hospital report in the patient medical record and share information during daily huddles with the physician and other members of the care team in preparation for the post-discharge visit.

Making Changes in Access

1. Explore how the primary care physician might participate in the discharge process, e.g., attending the discussions about the patient's care plan before or during discharge, either in person or remotely.
2. Explore how the practice can proactively provide the hospital(s) with a list of its high-risk patients so that staff at the hospital(s) can notify the practice on admission.
3. Schedule regular meetings for the office practice and the hospital key contact to review individual cases and ensure coordination and communication.

Making Changes in Access

4. **Place a liaison from the practice in the hospital.** At Family Care Network in Whatcom County, WA, the liaison facilitates the coordination of care by sharing information about the patient with the hospital team, flags the admission in the practice information system, triages anticipated post-discharge issues to the office practice nurse, makes the patient follow-up appointment, and notifies the practice when the patient is discharged. (IHI)

Making Changes in Access

Provide appropriate level and type of follow-up for high-risk, moderate-risk, and low-risk discharged patients. Patients who have been identified by the hospital clinicians as being at:

1. **High risk for readmission** should be seen by home health care or a primary care provider within 48 hours after discharge.
2. **Moderate-risk patients** should receive a follow-up phone call within 48 hours and be seen by a physician (or other provider) within five days.
3. **Low risk for readmissions,** an office visit should be scheduled per order of the discharging physician. (IHI)

Categorization of Risk

- **High-Risk Patients**
  - Patient has been admitted two or more times in the past year.
  - Patient is unable to teach back, or the patient or family caregiver has a low degree of confidence to carry out self-care at home.
- **Moderate-Risk Patients**
  - Patient has been admitted once in the past year.
  - Patient or family caregiver has a moderate degree of confidence to carry out self-care at home, based on Teach Back results.
- **Low-Risk Patients**
  - Patient has had no other hospital admissions in the past year.
  - Patient or family caregiver has high degree of confidence and can teach back how to carry out self-management (IHI)

Post-Discharge Phone Calls

- Many hospitals as well as health care plans, home health care agencies, and others are now conducting post-discharge follow-up phone calls with their patients.
- An office practice should know who is reaching out to their patients and avoid duplication.
- Patient information and educational materials across providers should be consistent, redundant calls reduced, and patients made aware of who will be contacting them, for what purpose, and within what time period. (IHI)

Post-Discharge Phone Calls

- A call from a primary care provider ensures that patients are contacted by someone they know and with whom they have a relationship.
- This communication provides an opportunity:

1. To adjust the risk assessment received from the hospital;
2. Establishes accountability of the practice for the patient;
3. Ensures continuity in the patient education process that began in the hospital and will now continue in the outpatient setting. (IHI)

Post-Discharge Phone Calls

At Cambridge Health Alliance clinics (Cambridge Health Alliance, Case Studies, page 66), a primary care practice nurse contacts high-risk patients within 12-18 hours following discharge and moderate-risk patients within 48 hours to:

1. Assess the patient's medical status,
2. Review the patient discharge information,
3. Elicit patient questions and concerns,
4. Confirm the scheduled follow-up appointment (made while the patient was in the hospital), and
5. Address other issues, such as medication refills or urgent appointments, as needed. (IHI)

Post-Discharge Appointment

- Ideally, patients are given their follow-up appointment before they leave the hospital. To accomplish this, the hospital can notify the practice about the need for an appointment and/or the primary care practice can contact the patient directly while he or she is in the hospital. The latter approach requires informing the practice that one of their patients is in the hospital and will require a follow-up appointment. This can be done through electronic communication, phone, or fax notification. (IHI)

Post-Discharge Appointment Measure

- Use this measure to determine the reliability of your processes for providing patients and their outpatient care providers with timely and appropriate care following a hospitalization:

  Percent of patients who are seen in an appropriate time frame following a hospitalization:

  1. High Risk -- 24-48 hours
  2. Moderate Risk – 5 days
  3. Low-Risk – at provider discretion (IHI)

2. Prior To The Visit

1. Review the discharge summary.
2. Clarify outstanding questions with sending physician(s).
3. Place a reminder call to the patient or family caregiver to help them prepare for the visit.
4. Coordinate care with home health care nurses and case managers if appropriate. (IHI)

2. Prior To The Visit

5. At the time of the first post-discharge office visit, the physician checks that: the treatment plan and medications ordered at discharge match his or her assessment of the patient's current clinical condition.

6. The physician and care team also ensure that the patient and family members are actively engaged in creating the care plan and capable of implementing it after discharge. (IHI)

2. Prior To The Visit

Seven Typical Failures

1. Primary or specialty care physician does not have the patient record, discharge summary, or medication list at hand for follow-up visit;
2. Outpatient physician may have trouble reaching the hospital-based physician in order to clarify information about the patient's condition, outstanding tests, and/or treatment plan;
3. Office practice team may not be aware of barriers for the patient to keeping their appointment (e.g., transportation, reliance on family members, etc.) (IHI)

2. Prior To The Visit

Seven Typical Failures

4. Outpatient physician does not always coordinate care with case managers or other community-based providers such as home health care nurses;
5. Patients do not know whom or when to call if their condition worsens;
6. Patients may not fully understand the importance of the first post-hospital visit; and
7. Patients have only a partial understanding of what they need to do and why, despite the use of methods to engage them during their hospital stays in learning about their care. (IHI)

2. Prior To The Visit

Recommended Changes

Review the discharge summary.

1. To adequately re-evaluate the patient's clinical status, the outpatient physician needs key pieces of information from the discharge summary in preparation for the first post-discharge visit. He or she also needs to be able to obtain additional information from the discharging physician. (IHI)

2. Prior to the Visit

Recommended Changes

Clarify questions with sending physician(s).

2. As the office practice physician or clinician reviews the discharge information, he/she may have questions for the sending physician. **The office practice clinician and the hospitalist or other hospital-based provider should establish a mutually agreed upon method of communication to facilitate the transfer of clarifying information to the office practice physician or other clinician. ..**The discussion about the preferred method of communication can occur at the same time that agreement is reached about the transfer of the discharge summary information. (IHI)

2. Prior to the Visit

Recommended Changes

Coordinate care with home health care nurses and case managers if appropriate.

3. The reminder call to the patient can be made by the physician or another member of the care team. The purpose of the call is to:

   Emphasize the importance of the visit and ensure that the patient will be able to come to the office on the day of the appointment (e.g., the patient has transportation, etc.). (IHI)

2. Prior to the Visit

Recommended Changes

Coordinate with home health and case managers

4. Remind the patient to **bring his or her list of medications** as well as the medications themselves, both over-the-counter and prescription medications that he or she is currently taking. **Short of visiting patients at home, having them bring their medications to the office is the best way to reconcile what the physician thinks they are taking with what they really are taking everyday.**
5. The physician or other care team member can also use the review of the medications to explore patients' understanding of their medications and reinforce teaching.
6. Make sure that patients know whom to contact for an emergency or to ask a question about their medications. (IHI)

2. Prior to the Visit

Recommended Changes

Review the discharge summary

In addition to reviewing the discharge information from the hospital, the office practice physician or clinician may want to obtain information from home health care nurses or non-clinic-based case managers.

7. The **home health** care nurse may have information about the patient's condition and medications prior to hospitalization,
8. He or she may have conducted the patient's first post-hospital visit.
9. **Case managers** would also have additional information about the patient's status at discharge, ability for self-care, and any family or social issues that would affect the physician's assessment of the patient's needs.
10. As with the hospitalist or hospital-based clinician, there should be a process to easily share information **between the office practice physician or other care team members and home health care, case managers, and/or other community-based providers or services.** (IHI)

2. Prior to the Visit: Suggested Measures

Use these measures to determine the reliability of your processes for preparing the clinical team prior to the first post-hospital visit:

- **Percent of first post-hospital visits when the physician 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. (IHI)**

3. During The Visit

- The first post-hospital visit is a key touch point for patients with their primary care provider (or specialist, depending on the clinical condition and the needs of the patient).
- The evidence is mixed concerning the effect of post discharge follow-up visits on readmission rates.
- While some studies report that post-discharge visits contribute to lower readmission rates others have not.

3. During The Visit

Recommended Changes

1. Ask the patient about his/her goals for the visit; what factors contributed to hospital admission or ED visit; and what medications he/she is taking and on what schedule.
2. Perform medication reconciliation with attention to the pre-hospital regimen.
3. Determine need to adjust medications or dosages, follow up on test results; do monitoring or testing; discuss advance directives; discuss specific future treatments and/or additional care support that may be needed.
4. Instruct patient in self-management (repeat back)
5. Explain warning signs and response (have repeat back.)
6. Provide instructions for seeking emergency and non-emergency after-hours care. (IHI)

3. During The Visit

Nine Typical Failures

1. Primary or specialty care physician does not have the patient record, discharge summary, or medication list at hand for follow-up visit;
2. Medications are not reconciled during the first post-discharge office visit;
3. Patients are not involved in decisions about their treatment plan and medications;

3. During The Visit

Nine Typical Failures

4. Patients are not provided with a comprehensive care plan that they understand and are confident they can follow;
5. Patients don't know whom and when to call if their condition worsens in the time after their appointment;
6. Lack of standardization between the hospital and office practice in information provided and in teaching methods;

3. During The Visit

Nine Typical Failures

7. Patient education focuses only on medications and excludes other concerns of the patient such as when and how to start exercising and diet;
8. Patients have only a partial understanding of what they need to do and why, despite the use of methods to engage patients in learning about their care; and
9. Failure of the office practice care team to recognize and provide support for patients with a low capacity for self-care due to low health literacy, financial barriers, other social problems, alternative health beliefs, substance abuse, or mental illness. (IHI)

3. During The Visit

Recommended Changes

Ask the patient:

- ***About his/her goals for the visit***
- ***What contributed to hospital admission or ED(ED) visit***
- ***What medications he/she is taking and on what schedule***

Starting the visit by asking the patient what is important to him/her helps the physician and the care team to develop a care plan with the patient that will meet his/her needs and that the patient and/or family members have had a role in creating.

The discharge summary does not usually contain information from the patient's perspective about what contributed to the hospital admission or ED visit. ***(IHI)***

3. During The Visit

Recommended Changes

Perform medication reconciliation with attention to the pre-hospital regimen. During the post-discharge visit, the physician uses information from:

- the patient and
- the clinical exam, and
- relevant information from the patient discharge information

to create a treatment plan and medication list.

Medication reconciliation is an especially important part of this process. **Failure to build a reliable process for medication reconciliation that involves the patient and family members can contribute to medication errors and can increase the risk of readmission to the hospital.**

3. During The Visit

Recommended Changes

Perform medication reconciliation with attention to the pre-hospital regimen.

- **A comprehensive medication reconciliation should begin with the physician or nurse practitioner asking the patients to say in their own words what medicines they are taking and when they are taking them.**
- This is often the best way for the clinician to get accurate information, rather than relying on the discharge medications.
- The clinician can identify and address discrepancies based on all relevant information: what the patient says he/she is taking, what was ordered at discharge, and what the medication regimen was prior to the hospitalization.

3. During The Visit

Recommended Changes

Determine need to

1. ***Adjust medications or dosages,***
2. ***Follow up on test results;***
3. ***Do monitoring or testing;***
4. ***Discuss advance directives;***
5. ***Discuss specific future treatments.***

The physician creates a treatment and medication plan and with the patient and/or family members, develops a care plan. Based on the discharge summary, the medication reconciliation process, and the clinical exam, the physician will determine the need to adjust medications or dosages, follow up on test results, and order additional monitoring or testing. (IHI)

3. During The Visit

Recommended Changes

Instruct patient in self-management; have patient repeat back.

Studies have shown that patients who are actively engaged in managing their care have:

- fewer hospitalizations,
- enjoy an improved quality of life, and
- experience better clinical outcomes.

Engaging and partnering with patients with heart failure can help improve care. Provider assessment and understanding of the patient's wishes and ability for self-care are crucial steps in engaging patients. The ability to understand and follow the instructions to take medications as prescribed, manage diet and other daily activities, and know when to ask for additional help is an essential component of patient engagement. (IHI)

Teach Back

- Teach Back involves asking patients or family caregivers to recall and restate in their own words what they heard during education or other instructions:

1. The clinician asks in a non-shaming way for the individual to explain in his or her own words what he/she understands.
2. Once a gap in understanding is identified, the clinician offers additional teaching or explanation followed by a second request for Teach Back.
3. "Return demonstration" or "show back" is another form of "closing the loop," in which the clinician asks the patient to demonstrate how he or she will do what was taught. This technique is used routinely in diabetic education and physical therapy. (IHI)

Teach Back

- Teach Back involves asking patients or family caregivers to recall and restate in their own words what they heard during education or other instructions:

1. The clinician assesses the patient's ability and confidence to perform self-care practices, including use of medications, diet, nutrition, symptom awareness and management, tobacco and alcohol use, activity, and reasons to call the physician (e.g., pain, weight gain, difficulty breathing, or exhaustion).
2. The clinician documents and communicates information about the patient or family member's understanding and goals to the care team and incorporates them into the patient's overall care plan. (IHI)

3. During The Visit

Recommended Changes

Explain warning signs and how to respond; have patient repeat back.

- The warning signs that patients should be aware of will differ from condition to condition. Providing patients and family members with easy-to-read instructions and tools can help patients safely monitor their symptoms and know when to contact the physician's office when appropriate. (IHI)

3. During The Visit

Recommended Changes

Provide instructions for seeking emergency and non-emergency after-hours care.

- Patients must not only know when to contact a physician for medical attention; they also need clear instructions on how to do so.
- For after-hours care, patients should know who to call and how to communicate that they are in an emergency situation.
- If the patient is being seen by multiple providers (e.g., specialists, palliative care, etc.), the providers should coordinate their instructions to the patient in order to eliminate any confusion for the patient and/or family members.
- Care team members may consider using what they learn about the patient's ability to repeat back these instructions for after-hours care as one indication of the patient's overall ability to self-manage. (IHI)

3. During the Visit: Suggested Measures

Use these measures to determine the reliability of your processes for conducting the first post-hospital office visit.

- 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. (IHI)

4. At The Conclusion Of The Visit

Recommended Changes

- **Communicate and Coordinate the Ongoing Care Plan**
  - Print reconciled, dated medication list and provide a copy to the patient, family caregiver, home health care nurse, and case manager, if appropriate.
  - Communicate revisions of the care plan to patient, family caregiver, home health care nurse, and case manager, if appropriate.
  - Ensure that the next appointment is made, as appropriate. (IHI)

4. At The Conclusion Of The Visit

Six Typical Failures

associated with communicating and coordinating the ongoing care plan with patients and across outpatient providers and settings include the following:

1. Patients leave the office visit with questions about what they should do when they get home (e.g., medications, eating plan, etc.);
2. Primary care physicians who lack the time or confidence to sufficiently manage the care of patients with complex medical conditions after discharge (e.g., adjusting medications for patients after a specialist visit or consultation or following a hospitalization); (IHI)

4. At The Conclusion Of The Visit

Six Typical Failures

3. Lack of agreement between specialists and primary care physicians about which physicians are responsible for managing the patient's condition in the short or long term;
4. Lack of communication to providers when their patients with multiple conditions are discharged from the hospital;
5. Poly-pharmacy issues due to prescriptions by multiple providers and a lack of oversight of the patient's overall medication regimen or treatment plan; and
6. Home health care agencies, skilled nursing facilities and other supportive services are not provided with an updated care plan for their past/current patients. (IHI)

4. At The Conclusion Of The Visit

- **What are your typical failures and opportunities for improvement?**

  - Review the findings from Section IV, Step 3 in Identifying Opportunities for Improvement, page 43. Periodically repeat Step 3 to continually learn about opportunities for improvement. Use the **Observation Guide: Observing Current Processes for the First Post-Hospital Visit** (How-to Guide Resources, page 75).
  - Tip: Use your findings from the third section of the Observation Guide, which focuses on what happens at the conclusion of the visit. What did you learn? (IHI)

Observation Guide

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

Observe what happens for patients and for office practice providers and staff prior to – and on the day of – the first post-hospital visit. Reflect upon what you observed to discover what went well and where there are opportunities for improvement.

What do you predict you will observe?

Did the care team member(s)…	Patient # 1		Patient # 2		Patient # 3	
	Yes	No	Yes	No	Yes	No
Prior to the office visit:						
Schedule a follow-up visit within 48 hours for high-risk patients or within five days for moderate- or low-risk patients?	☐	☐	☐	☐	☐	☐
Have all the information that they needed about the patient prior to the visit?	☐	☐	☐	☐	☐	☐

Observation Guide

During the office visit:								
Ask the patient to explain his/her goals for the visit?	☐	☐	☐	☐	☐	☐	☐	☐
Determine need to adjust medications or dosage?	☐	☐	☐	☐	☐	☐	☐	☐
Discuss advance directives?	☐	☐	☐	☐	☐	☐	☐	☐
Instruct patient in self-management, having patient repeat back?	☐	☐	☐	☐	☐	☐	☐	☐
Explain warning signs to the patient and how to respond, having patient repeat back?	☐	☐	☐	☐	☐	☐	☐	☐
Provide instructions for seeking emergency and non-emergency care?	☐	☐	☐	☐	☐	☐	☐	☐
At the conclusion of the visit:								
Print reconciled medication list with copies for patient, family, and community providers?	☐	☐	☐	☐	☐	☐	☐	☐
Communicate revisions to the care plan to patient, family, and community providers?	☐	☐	☐	☐	☐	☐	☐	☐
Make next appointment as appropriate?	☐	☐	☐	☐	☐	☐	☐	☐

Observation Guide

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?

Observation Guide

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.

4. At The Conclusion Of The Visit

Recommended Changes

Print reconciled, dated medication list and provide a copy to the patient, family caregiver, home health care nurse, and case manager, if appropriate.

The reconciliation of medications that the patient was taking before and after discharge is an important component of what happens during the office. (IHI)

4. At The Conclusion Of The Visit

Recommended Changes

Communicate revisions to the care plan to the patient, family caregiver, home health care nurse, and case manager, if appropriate. Patients at high risk of readmission often:

- have multiple clinical conditions and
- are treated by a number of different clinicians.

Following the post-discharge visit, send updated information about the patient's treatment plan and medications, especially any changes in the patient's condition and ability to care for him/herself, to all providers caring for the patient. (IHI)

4. At The Conclusion Of The Visit

Recommended Changes

Communicate revisions to the care plan to the patient, family caregiver, home health care nurse, and case manager, if appropriate.

The office practice should designate a team member to be responsible for sending the care plan developed at the first post-discharge office visit as well as the reconciled medical list to other clinicians and providers in the community, highlighting any changes in medications since discharge. Some considerations in developing this process include: (IHI)

4. At The Conclusion Of The Visit

Recommended Changes

Communicate revisions to the care plan to the patient, family caregiver, home health care nurse, and case manager, if appropriate.

1. Ensure that primary care providers and specialists (and/or others who will be receiving the care plan) agree on a preferred method of communication (e.g., fax, secure e-mail, etc.). More information at.
2. There should also be a mutually agreed upon method of communication for providers to follow up with each other with questions after the receipt of the care plan. (IHI)

4. At The Conclusion Of The Visit

Recommended Changes

Communicate revisions to the care plan to the patient, family caregiver, home health care nurse, and case manager, if appropriate.

3. Ensure that all providers agree on a timeframe for the physician who is conducting the post-discharge exam to send an updated care plan the day of the visit.
4. If the patient is has difficulty reading or understanding instructions, ensure that the physician conducting the post-discharge exam notifies other providers so they can be prepared to better assist the patient during the next interaction. (IHI)

4. At The Conclusion Of The Visit

Recommended Changes

Ensure that the next appointment is made, as appropriate.

- At the conclusion of the office visit, the patient should also receive an appointment for his/her next office visit or phone contact.
- The care team should also arrange for any additional support services that might be needed following the visit (e.g., behavioral health or substance abuse services, meals on wheels, social support, financial assistance, housing assistance, or help with transportation) and inform the patient of the scheduled services. (IHI)

4. At The Conclusion Of The Visit: Suggested Measures

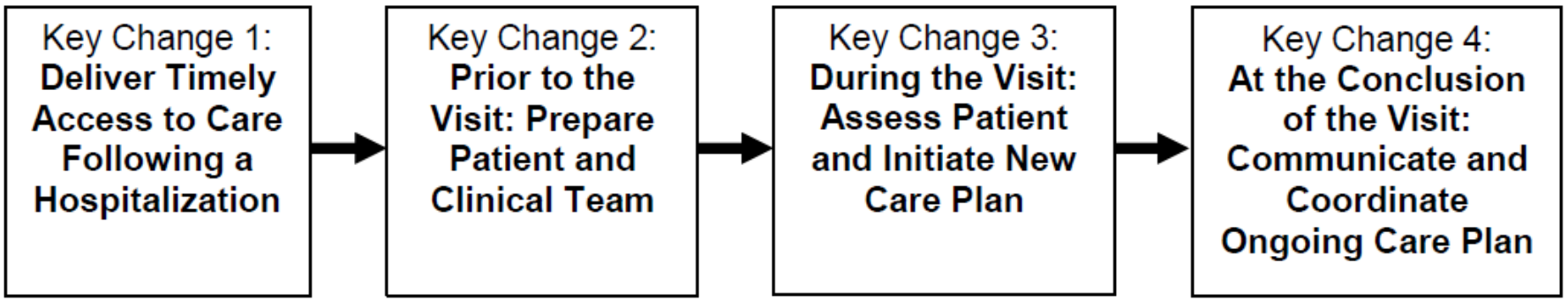
Use these measures to determine the reliability of your processes for concluding the first post-hospital office visit:

- 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 (IHI)

Suggested Process Measures

Key Changes	Process Measures
Deliver Timely Access to Care Following a Hospitalization	• Percent of patients who are seen in an appropriate time frame (i.e., two days for high-risk, five days for moderate-risk, and at provider discretion for low-risk patients)
Prior to the Visit: Prepare Patient and Clinical Team	• Percent of first post-hospital visits when the physician 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
During the Visit: Assess Patient and Initiate New Care Plan	• 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
At the Conclusion of the Visit: Communicate and Coordinate Ongoing Care Plan	• 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

Flow Chart of Key Changes



SETMA's Tools for Fulfilling IHI's Strategy

SETMA has been working on tools for improving care for seventeen years. At HIMSS 2012, my presentation linked below detailed the development of those tools.

http://www.jameslhollymd.com/HiMSS2012-Care-Transitions-The-Heart-of-Patient-Center-Medical-Home.cfm

The tools specifically relevant to IHI's work are:

1. Hospital Service Team

- One or more team members are in the hospital full-time (24/7) to establish continuity of care.
- Electronic health record used in the clinic is used in the hospital, emergency department, nursing home, home health, hospice, etc.
- Communication with all providers is via a common date base, iPhones, iPads, pagers, telephone, secure web portal and health information exchange.

SETMA's Tools for Fulfilling IHI's Strategy

2. Hospital Admission Plan of Care

This is a personalized document which is completed and given to the appropriate person: patient, family member, medical power of attorney and/or primary care giver. It consists of:

- Reason for Admission
- Admission Diagnoses
- Estimated Length of Hospitalization
- Plan of Care while in Hospital
- How to contact Hospital Service Team while in Hospital

This document is automatically generated and is a step in improving patient understanding, engagement and trust in their care.

SETMA's Tools for Fulfilling IHI's Strategy

3. Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan (previously called the "Discharge Summary")
   - This document is explained at www.jameslhollymd.com under *Electronic Patient Management Tools*, *Hospital Based Tools*, *Discharge Summary Tutorial*.
   - This document is given to the patient/family/care giver at the time of discharge from the hospital, 98.7% of the time.
   - This document includes a reconciled medication list, follow-up appointments, instructions for self-care, etc.
   - This document assesses the patient's risk of readmission.

SETMA's Tools for Fulfilling IHI's Strategy

4. Care Coordination

- A Care-Coaching call with further follow-up calls as appropriate is completed the day following discharge from the hospital – 12-30 minute call. This call is scheduled by the hospital service team.
- SETMA Foundation resources available for patients who cannot afford medications, co-pays, DME, etc., in order to eliminate financial barriers to care.
- Other community resources arranged by Care Coordination Department as needed.
- When patient is designated as high-risk for readmission a ten-step process is instituted for supporting the patient.

SETMA's Tools for Fulfilling IHI's Strategy

5. Business Intelligence (BI) Analytics

SETMA has adapted a BI product to analyze hospitalized patients, contrasting those who are not readmitted and those who are. This allows the identification of points of leverage for eliminating preventable readmissions. Some of the analytics looks at ethnicity, morbidities, co-morbidities, socio-economic, gender, age, etc.

SETMA's Tools for Fulfilling IHI's Strategy

6. Identification of High Risk Patients

Once SETMA, identifies a patient as high-risk for readmission, he/she is entered into a treatment program with ten steps. Slides 30-33 at the following link give the details of that program.

http://www.jameslhollymd.com/Preventable-Hospital-Readmissions-Policy-Problems-Processes.cfm

SETMA's Tools for Fulfilling IHI's Strategy

7. PCPI (Physician Consortium for Performance Improvement, AMA) Care Transitions Measurement Set

   - 14 data points and 4 action items make up this quality metric set.
   - SETMA deployed it in June 2009, when it was published.
   - SETMA continues to complete 98.7% of the Hospital Care Summary and Post Hospital
   - Plan of Care at the time the patient leaves the hospital (in 40 months over 13,000 admissions and discharges)

SETMA's Points of Leverage

1. The problem of readmissions will not be solved by more care: more medicines, more tests, more visits, etc.

2. The problem will be solved by redirecting the patient's attention for a safety net away from the emergency department.

3. The problem will be solved by our having more proactive contact with the patient.

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SETMA's Points of Leverage

4. The problem will be solved by more contact with the patient and/or care giver in the home: home health, social worker, provider house calls.

5. The problem will be solved by the patient and/or care giver having more contact electronically (telephone, e-mail, web portal, cell phone) with the patient giving immediate if not instantaneous access.

SETMA's Points of Leverage

Seamless Collaboration Between:

- Hospital Care Team
- Care Coordination Department
- I-Care (Nursing Home) Team
- Healthcare Providers
- Clinic Staff

The key to success is the building of a great team.

SETMA's Points of Leverage

Barriers to Deploying some IHI's Recommendations

1. Requirements for addition cost in time, personnel and money.
2. Primary Care Provider attending hospital patient planning conferences
3. Complexity of getting over-stressed families involved in patients' care.

SETMA's Points of Leverage

Changes Based on IHI Recommendations:

- Place a follow-up-visit-reminder call to all patients discharged in addition to their care coaching call
- Get family actively involved in care before patient leaves the hospital.
- Improve the quality of hospital follow-up visits.
- Utilize the Observation Guide for Observation of Current Processes for the First Post-Hospital visit to improve the quality and content of that visit.

SETMA's Points of Leverage

When a person is identified as a high risk for readmissions, SETMA's Department of Care Coordination is alerted. The following ten steps are then instituted:

1. ***Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan*** is given to patient, care giver or family member.
2. The post hospital, care coaching call, which is done the day after discharge, goes to the top of the queue for the call – made the day after discharge by SETMA's Care Coordination Department. It is a 12-30 minute call.

SETMA's Points of Leverage

3. Medication reconciliation is done at the time of discharge, is repeated in the care coordination call the day after discharge and is repeated at the follow-up visit in the clinic.
4. MSW makes a home visit for need evaluation, including barriers and social needs for those who are socially isolated.
5. A clinic follow-up visit within three days for those at high risk for readmission.

SETMA's Points of Leverage

6. A second care coordination call in four days.
7. Plan of care and treatment plan discussed with patient, family and/or care giver at EVERY visit and a written copy with the patient's reconciled medication list, follow-up instructions, state of health, and how to access further care needs.
8. MSW documents barriers to care and care coordination department designs a solution for each.

SETMA's Points of Leverage

9. The patient's end of life choices and code status are discussed and when appropriate hospice is recommended.
10. Referral to disease management is done when appropriate, along with tele-health monitoring measures.