Follow-up and Plan of Action
SETMA's June 26, 2012 Provider Training
Review of IHI's *Improving Transitions from the Hospital to The Clinical Office Practice to Reduce Avoidable Rehospitalizations*

Outline of the training session:

We reviewed the IHI document on transition from the hospital to the clinical office. We review the tools which SETMA has developed over the past fourteen years to help us accomplish the tasks outlined by IHI. This review is of each of the recommendations, typical failures and actions recommended. The legend for this review is that:

- Those recommendations which SETMA is presently performing excellently will be highlighted in **BLACK**.
- Those recommendations which SETMA is presently not performing will be highlighted in **RED.**
- Those recommendations in which SEMTA needs improvement will be highlighted in **PURPLE**.

IHI Four Recommended Changes

IHI identified 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" An analysis of SETMA's performance for each is followed by an analysis of SETMA's tools for fulfilling the tasks of each of these recommendations.

1. **Provide timely access to care following a hospitalization (page 2f)** SETMA's Tools (page 4f)
2. **Prior to the visit, prepare the patient and the clinical team; (page 6f)** SETMA's Tools (page 7f)
3. **During the visit, assess the patient and initiate a new care plan or revise an existing care plan; and (page 8f)** SETMA's Tools (page 10f)
4. **At the conclusion of the visit, communicate and coordinate the ongoing care plan. (IHI) (Page 11f)** SEMTA's Tools (page 12)

Over the next several weeks, and before our July Provider Training in which we will study the second of the IHI transitions of care documents, we will make some recommendations specific for SETMA for fulfilling these four functions.

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;**
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;**
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)**

Making Changes

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

3. **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.**
4. **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.**
5. **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.**
6. **Schedule regular meetings for the office practice and the hospital key contact to review individual cases and ensure coordination and communication.**
7. **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)**
8. ***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 as:**
    a. **High risk for readmission should be seen by home health care or a primary care provider within 48 hours after discharge.**
    b. **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.**
    c. **Low risk for readmissions, an office visit should be scheduled per order of the discharging physician. (IHI**
9. **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.**
10. **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 appointments

- **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)**
- **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)**

SETMA Tools for Dealing with Timely Access to Care

1. **Hospital Admission Plan of Care – document prepared and given to patient, family or provider upon admission. This and all documents are completed in the same EMR making them instant available to all providers.**
2. **Hospital Care Summary and Post Hospital plan of Care and Treatment Plan (formerly called the Discharge Summary). Over the past 40 months, we have discharged over 13,000 patieens from the hospital and 98.7% of the time, the Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan has been completed at the time of discharge and a copy given to the family.**
3. **Same EMR and CDS tools used in clinic, hospital, ED, Nursing Home..**
4. **Seven-day-a week, twenty-four-hours –a-day, full-time SETMA staff in hospital for liaison, communication, continuity and transitions of care. This has been so for twelve years.**

5. **Care Coordination hospital discharge, care coaching call (12-30 minutes the day after discharge for all patients. If a patient is designated as high risk for rehospitalizations, they go into a ten-step program. The following is a audit of the number of calls made and missed.**

Hospital follow-up calls:

- **January 479 calls. *Of these 0 were high risk patients. (High risk designation not in place at this time.)* -- 13 were Clinic Follow-up Calls.**
- **February 473 calls -- *Of these 21 were high risk patients.* 24 were Clinic Follow-up Calls – a high risk patient receives a clinic follow-up call the day after their hospital follow-up appt.**
- **March 543 calls. -- *Of these 64 were high risk patients.* 41 were Clinic Follow-up Calls – a high risk patient receives a clinic follow-up call the day after their hospital follow-up appt.**
- **April 558 calls. -- *Of these 29 were high risk patients.* 29 were Clinic Follow-up Calls – a high risk patient receives a clinic follow-up call the day after their hospital follow-up appt.**
- **May 513 calls. -- *Of these 29 were high risk patients.*18 were Clinic Follow-up Calls – a high risk patient receives a clinic follow-up call the day after their hospital follow-up appt.**
- **June 1st – June 22nd 379 calls. -- *Of these 9 were high risk patients.* 6 were Clinic Follow-up Calls – a high risk patient receives a clinic follow-up call the day after their hospital follow-up appt.**

Missed hospital follow-up appointment calls:

- **February 59 calls.**
- **March 61 calls.**
- **April 53 calls.**
- **May 51 calls.**
- **June 1st – June 22nd 43 calls.**

(If a patient cannot be contacted by telephone after three attempts, a letter is automatically created and mailed t the patient)

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)**
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)**

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)**
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)**

Recommended Changes

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. **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)**
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.).***
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)**

SETMA Tools for Dealing with Prior to the Visit

Including the tools described above, SETMA has

1. **Coordination of Care template which allows for documentation of barriers to care, referral to the SETMA Foundation for care needs which require financial support**
2. **Coordination of Care templates which makes it simple to refer patients for care coordination to that department.**
3. **Secure e-mail communication with patents and other providers**
4. **Health Information Exchange which allows information to be shared across providers' practices who do not use the same EMR.**
5. **Transitions of care documents from hospital available in the clinic EMR 98.7+% of the time.**
6. **Medication reconciliation done upon admission, discharge, and care coaching before patient is seen in the follow-up visit and all are done in the meta data base.**

3. During the Visit

Recommended Changes

- **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.**
- **Perform medication reconciliation with attention to the pre-hospital regimen.**
- **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.**
- **Instruct patient in self-management (repeat back)**
- **Explain warning signs and response (have repeat back.)**
- **Provide instructions for seeking emergency and non-emergency after-hours care. (IHI)**

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;**
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;**
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)**

Recommended Changes

1. **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***

2. **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.**

3. **The discharge summary does not usually contain information from the patient's perspective about what contributed to the hospital admission or ED visit.** ***(IHI)***
4. ***Perform medication reconciliation with attention to the pre-hospital regimen.*** **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.**
5. **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.**
6. ***Determine need to***

    a. ***Adjust medications or dosages,***
    b. ***Follow up on test results;***
    c. ***Do monitoring or testing;***
    d. ***Discuss advance directives;***
    e. ***Discuss specific future treatments.***

7. **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)**
8. ***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.**
9. ***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)**
10. ***Provide instructions for seeking emergency and non-emergency after-hours care.***

a. **Patients must not only know when to contact a physician for medical attention; they also need clear instructions on how to do so.**
b. **For after-hours care, patients should know who to call and how to communicate that they are in an emergency situation.**
c. **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.**
d. **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)**

SETMA Tools for Dealing with During the Visit

1. **As a part of SETMA's Patient-Centered Medical Home and because of our partnership with hospice, advanced directives are part of our quality management program.**

2. **As par of the Hospital Care Summary and the Post Hospital Plan of Car and Treatment plan, patients receive follow-up appointments prior to leaving the hospital. This document identifies all procedures and/or test results which are not reporting and explains to the patient how they will get those results.**

3. **The Hospital Care Summary includes explicit statements of why the patient came to the hospital and why they were admitted.**

4. **SETMA has around the clock communications with our patients by multiple means and methods to maintain continuity of care and patient safety.**

4. At the Conclusion of the Visit

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,**

Six Typical Failures

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)**
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)**

Recommended Changes

1. **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 visit.**

2. ***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 patient.**
3. ***Communicate revisions to the care plan to the patient, family caregiver, home health care nurse, and case manager, if appropriate.***
4. ***Communicate revisions to the care plan to the patient, family caregiver, home health care nurse, and case manager, if appropriate.***
5. ***Communicate revisions to the care plan to the patient, family caregiver, home health care nurse, and case manager, if appropriate.***
6. ***Ensure that the next appointment is made, as appropriate.***

SETMA Tools for Dealing with Conclusion of the Visit

The most important tool which SETMA has developed is a team which continually communicates with each member personally, electronically, telephonically and documentarily. The simultaneous sharing of patient encounter material across a continuum and at every point of care for the patient is the foundational tool for the fulfillment of all of our efforts to decrease rehospitalizations.