Team-Based Transition Management- A Hospital Discharge Follow Up Process

PRESENTERS:

ANDREW ATKINS

DIANA NICHOL

Tilbury District
FAMILY HEALTH TEAM

Tilbury District
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Conflict of Interest Statement

We do not have any relationships with financial sponsors

We do not have any conflicts of interest and therefore no bias

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Who are we…?

Andrew Atkins

Quality Improvement Decision Support Specialist (QIDSS)

ESC LHIN-1 FHTs

Something interesting about me:

I'm getting married next week

Diana Nichol

Quality Improvement and Effective Transitions Lead at TDFHT

Registered Nurse

Member, HQO Transitions from Hospital to Home Advisory Standards Committee

Something interesting about me:

I enjoy reading books about theories of the universe

Hospital Discharge Follow Up Trailer

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What We Hope You Will Take Away from Today

1. Implement a patient centered , team-based approach to managing patient transitions from hospital to home in a primary care setting
2. Capture and identify all hospital discharged patients using your EMR
3. Have a meaningful and effective follow up with all in-patient discharges within 7 days (no triaging, no eligibilities)
4. Use your team to increase capacity in effectively managing patient transitions
5. Use additional modules with your process depending on available resources and team focus

QIP Priority Indicator

7-day Post Discharge Follow Up (any provider)

"Number of Hospital Discharges (any condition) where timely (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge"

- HQO indicator Library

Who’s in our audience today?

How many people currently have no structured process in place?

Have a process that you want to improve?

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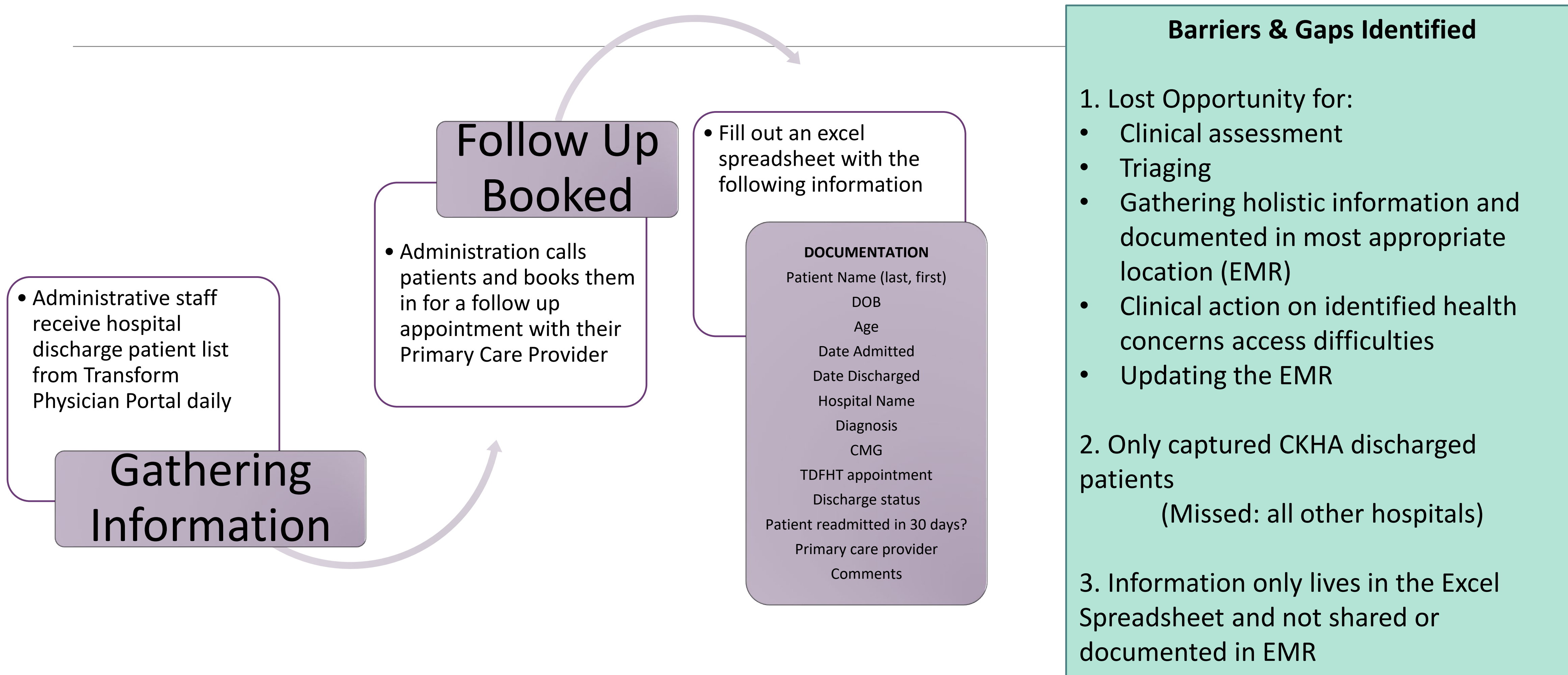
TDFHT Old Hospital Discharge Process



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Why did we change?

Intensive case management program success supporting only a certain populations through transitions in care from hospital to home

Identified that all patients experiencing transitions could benefit from this model of care

There were similar themes identified in helping patients through transitions such as:

1. Patients unsure who to contact with questions or concerns
2. Medication list discrepancies
3. Under utilization of primary care post discharge resulting in inappropriate visits to ER or readmissions
4. Wasted time during follow up appointments searching for information

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“Our Story” – illustrated by Data

- Struggles of the old process
- Ups and Downs of the new process

7-Day Hospital Discharge Follow-up Rate

100%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
7 Day Follow-up Rate
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
30 Day Follow-up Rate
Nurse Training– January 2018
New Responsibilities - August 2018
Nurse Training– September 2018
July-2016
October-2016
January-2017
April-2017
July-2017
October-2017
January-2018
April-2018
July-2018
Month of Follow-up

The trends of 7 Day Follow-up Rate and 30 Day Follow-up Rate for Follow-up Month. Color shows details about 7 Day Follow-up Rate and 30 Day Follow-up Rate.

Measure Names
30 Day Follow-up Rate
7 Day Follow-up Rate

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Success

what people think it looks like

Success

what it really looks like

Internal Assessment & Goals

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Internal Assessment	Goals	Misalignments
Questions to consider: 1. Who's on my team? Do we have a committee for this project? 2. How big is my team? 3. What are we already doing? (taking a patient journey, and document trail) 4. Understanding patient roster/population/needs (using your EMR) 5. # discharges/month 6. What kind of education do we need? 7. What type of technology do we have? (HRM, EMR) 8. Who will be a part of the process?	Items to consider: 1. Using your internal assessment, calculate resources expected to accomplish the goal you set. 2. What do you want to accomplish? (are you only following up with patients from one hospital? Do you want to expand to all hospitals?) 3. All patients? Inpatient? ED? All hospitals? One hospital? 4. Only certain conditions? 5. Do we want to have additional modules? (screening, med rec)	Internal Assessment vs. Goals

TDFHT Internal Assessment

Resources	Patient Population	Technology	Education	Current Process	Demand
6 RPNs 3 RNs 2 Diabetes educators 1 CHF/COPD educator 2 social workers 8 PCP's	13,400 rostered 47.5% >50 y/o Rural	What we have: HRM Accuro Faxes go to one clerical person who index's them Clinical Connect	What we have: Case management Healthcare navigation	Book CKHA discharged patients in for follow up appointment only done by clerical	50-80 follow ups/ month

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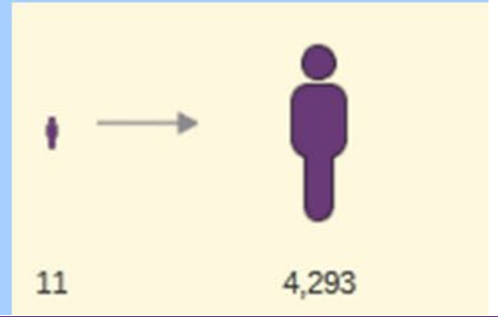
Where do our patients live?

Windsor-Essex

Chatham- Kent

Sarnia-Lambton

11; Port Lambton
177; Wallaceb
20; Tupperville
Dresden
113; Thamesville
28; Kent Bridge
65; Dover Centre
81; Ridgetown
26; Morpeth
119; Pain Court
4,293; Chatham
81; Charing Cross
Blenheim
30; North Buxton
28; Cedar Springs
25; Erieau
769; Merlin
20; Port Alma
88; Coatsworth
3,831; Tilbury
346; Comber
19; Ruscom
33; Woodslee
425; Stoney Point
71; St. Joachim
261; Windsor
14; Tecumseh
26; Essex
11; Cottam
16; Amherstburg
669; Wheatley
25; Ruthven
27; Kingsville
Leamington



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The *New* Hospital Discharge Follow-up Process

1. Modular design to accommodate any team
2. Specifically designed to be shared
3. Currently has been shared with the FHTs within our LHIN
4. Accommodates different populations, resources and demographics
5. Teams can pick and choose which module works for them
6. Patient centered

The Core Module – Hospital Discharge Follow Up Phone Call

1. Tools
2. Identify
3. Track & Delegate
4. Chart Review
5. Making the Phone Call
6. Action

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Core Module- Tools

ALL NEW INGREDIENTS
#Chopped

- EMR Query
- Process Maps
- Follow-up Form Reference Guide
- Follow-up "How to" Guide
- Excel Discharge Tracking Template
- Hospital Discharge Follow-up rate calculator

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Team-Based Transition Management- A Hospital Discharge Follow-up Process

Core Module

IDENTIFY discharged patients:
Physician Portal
EMR Query
In-Patient E-notification
Physician tasks

Follow-up TRACKING
Excel Tracker Spreadsheet
Tasks in EMR

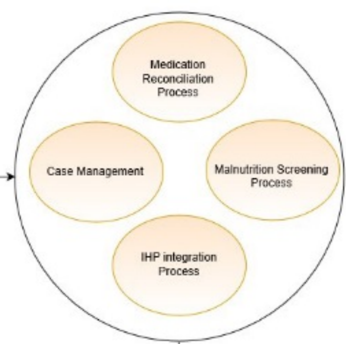
CHART REVIEW
E-notifications
Consultation reports
History & Physical
Operative reports
Discharge Summary
Med Lists

Nurse/IHP calls patient

Does patient answer?

YES

Complete "Hospital Discharge Follow-up Assessment Form"
- update EMR
-IHP/Nursing assessment
-Health Teaching
-Assess for community services involved
-Consult physician for immediate needs
-Provide contact information
-Schedule appoinemnts



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NO

Voice mail left and phone call indicated in EMR

was this the 2nd attempt to call patient?

NO

Verify contact information/ Wait 24-48 hours

YES

Leave 2nd voice message and indicated in EMR

Complete "Hospital Discharge Follow Up Form" with information that is available

All appropriate IHPs Tasked with attached completed "Hospital Discharge Follow up Form" to review

IHP follows up with patient via phone call if required and determines follow up appointment

Patient booked in for follow up with PCP/IHP same day/next day/urgent care/next available appointment

Did patient show up for appointment?

NO

Reception tasks nurse/IHP to follow up and reassess patient situation

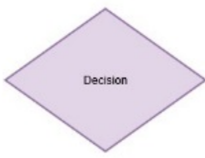
YES

Nurse/IHP/PCP reviews/ completes Hospital Discharge Follow up Form

Hospital Discharge follow up form shared with appropriate person (s) of circle of care

Patient successfully followed up with post hospital discharge
OR
All efforts to follow up with patient exhausted

Legend



Core Module – Identifying Discharges

1. Query/ Searches done every morning (Mon-Sat)
2. Physician/Document Tasking on LHSC and other hospitals we do not receive notification from
3. Data Quality Assurance query run every Friday
4. Physician Portal (validation)

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Medication Reconciliation Process
Case Management
Malnutrition Screening Process
IHP integration Process

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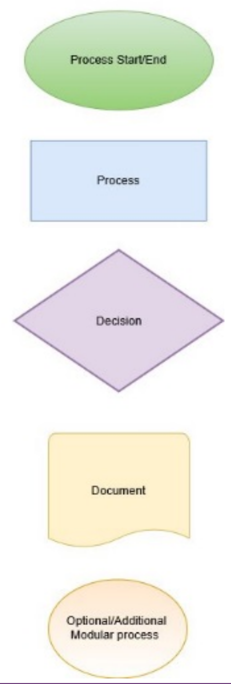

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Core Module - Tracking Discharge Follow Ups

Excel Template	EMR Task
PROS • One space for multiple nurses to access • Can colour code • Can visualize all past and upcoming follow ups CONS • Does not document all actions in EMR • Reworking/ Double documenting • All discharged patient information in one document (privacy)	PROS • Documents patient discharge identify date and all follow up actions in their EMR • Secure CONS • Deletes task immediately once it is completed, difficult to trace back if you forgot something • Not for the visual person • Difficult to do quick daily audits on patients followed up by others

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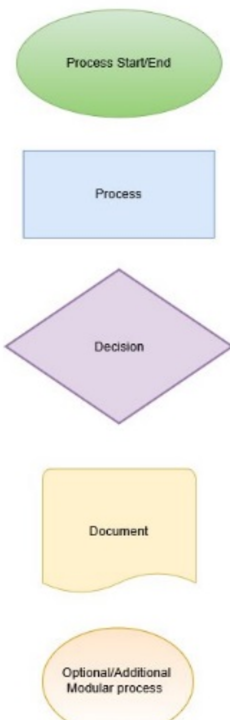

Core Module – Chart Review

1. Brief chart review to become familiar with the patient's story relevant to the admission
2. Review previous admissions of similar or same complaint to piece together the patient's struggles
3. Gather sources for med rec if you will be implementing that module
4. Updating EMR during chart review

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Team-Based Transition Management- A Hospital Discharge Follow-up Process

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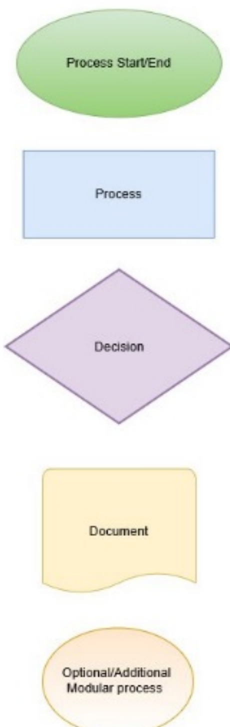

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Core Module– Making the phone call

1. The opening statement
2. Script templates
3. Using the “Hospital Discharge Follow Up Form” as a guideline for your conversation

Hospital Discharge Follow-up

Form Date
Feb 1, 2018
Form Completed by
Diana Hegedus

Admission Date: MM/DD/YYYY
Discharge Date: MM/DD/YYYY
Reason for Visit:

☐ **This was a 30-day readmission**

Hospital: **Chatham Kent Health Alliance**

Discharge Disposition: **Home**

Follow-up Required? ☐ Yes ☐ No

CMG
- ☐ Cardiac
- ☐ CHF
- ☐ COPD
- ☐ Diabetes
- ☐ GI
- ☐ Mental Health
- ☐ OB
- ☐ Pneumonia
- ☐ Stroke
- ☐ Surgery

LHIN Services
- ☐ Nursing
- ☐ PSW
- ☐ PCCT
- ☐ PT
- ☐ OT
- ☐ Clinic
- ☐ R R Nurse
- ☐ Telehome
- ☐ None

Primary Care Provider
Dr. Jean-Marc Beausol

Patient Name
Brice2 (Bricey) Test

Patient Age
55 Yr

Follow-Up Appointments

MM/DD/YYYY	
MM/DD/YYYY	
MM/DD/YYYY	
MM/DD/YYYY	

TDFHT Follow-up Appointment Booked

Patient's Situation

Medication Changes? ○ Yes ○ No

Med Rec task sent to Pharmacist? ○ Yes ○ No

HARP Score Readmission Risk Level

Program Involvement
- ☐ Diabetes Education
- ☐ Foot Care
- ☐ Health Link
- ☐ Lung Health
- ☐ Mental Health
- ☐ Nutrition
- ☐ Smoking Cessation

Health teaching required? ○ Yes ○ No

Diagnosis list updated? ○ Yes ○ No

Surgery/Procedure list updated? ○ Yes ○ No

Lifestyles list updated? ○ Yes ○ No

Core Module – Action

1. Action upon every abnormal finding
2. Sharing your assessment amongst your team and beyond
3. Booking and coordinating appointments
4. Ensuring patients don’t fall through the cracks

Additional Modules

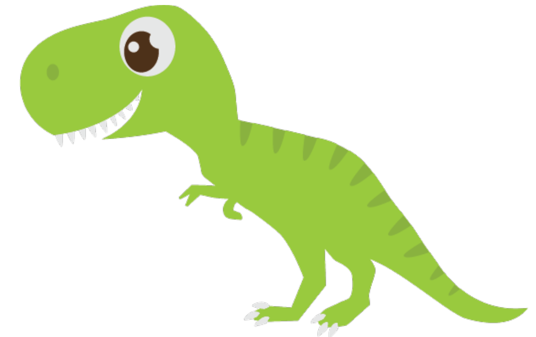
Each additional module you can choose from to add to your Hospital Discharge Follow Up Process

You can always add or remove these modules depending on available resources or change In demands

Modules depending on focus of the team or QIP

Module 1 - Medication Reconciliation

1. 3 que's for a med rec
2. The Med Rec team: RNs, RPNs, Pharmacist, PCPs
3. Multiple Medication List Sources
4. Sharing the med rec
5. Collecting med rec data



Med Rex

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Team-Based Transition Management- A Hospital Discharge Follow-Up Process

Module 1 - Medication Reconciliation

IDENTIFY discharged patients:
Physician Portal
EMR Query
In-Patient E-notification
Physician tasks

→ **Follow-up TRACKING**
Excel Tracker Spreadsheet
Send follow up tasks in EMR to appropriate IHP

→ **CHART REVIEW**
E-notifications
Consultation reports
History & Physical
Operative reports
Discharge Summary
Med Lists

→ Medication Changes?
- NO → No med rec required
- YES → Nurse/IHP access all possible med list sources
  -Clinical Connect DHDR
  -Primary Pharmacy
  -Discharge med card

→ Any outstanding med lists requested comes to FHT via fax and labeled "Pharmacy Med List"

Hospital Discharge Medication List "Med Card" faxed to TDFHT from Hospital

→ Admin "Tasks" Pharmacist and follow up nurse/IHP with the list

→ Pharmacist or nurse/IHP starts med rec (who ever gets to the task first)

→ Print out EMR med list and Discharge Summary Report AND/OR Pharmacy med list AND/OR Clinical Connect DHDR home meds (3 sources required including patient)

→ Compare lists and determine discepancies

→ **Module 1 - Hospital Discharge Follow-up Process**

→ Call patient for Hospital Discharge Follow Up and verify discepancies

→ Is patient able to verify medication reconciliation over the phone?
- YES → Update EMR Med List
- NO → Is there an appointment available with the pharmacist for a med review?

Patient shows up to TDFHT post hospital discharge with no previous follow up attempt → Is there an appointment available with the pharmacist for a med review?
- YES → Patient booked in with pharmacist for a med rec/review same day as or before upcoming FHT follow-up appointment → Update EMR Med List
- NO → Nurse/IHP/PCP completes med rec at appointment → Update EMR Med List

Update EMR Med List → Nurse/IHP creates a med rec note in EMR summarizing the changes made to the medication list
OR
Nurse/IHP "Tasks" Pharmacist with all changes made to med list if a med review is required
OR
Pharmacist creates a med rec note in EMR summarizing the changes made to the medication list and any recommendations

→ Complete the "Med Rec" Band in EMR indicating reason for Med Rec "Hospital Discharge", date completed and name and designation

→ Med Rec completed and shared with appropriate members of circle of care
-PCP
-Primary Pharmacy
-Home and Community Care

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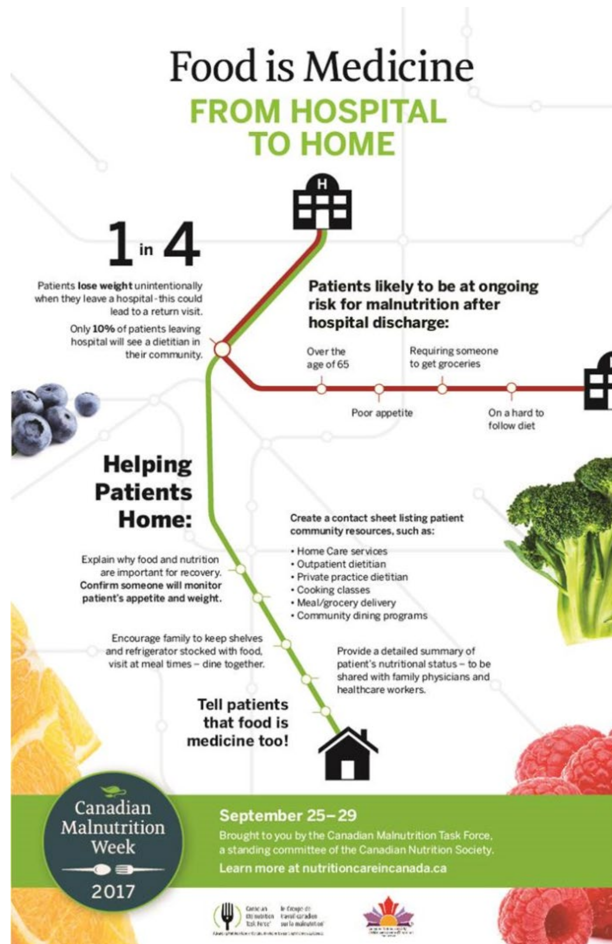
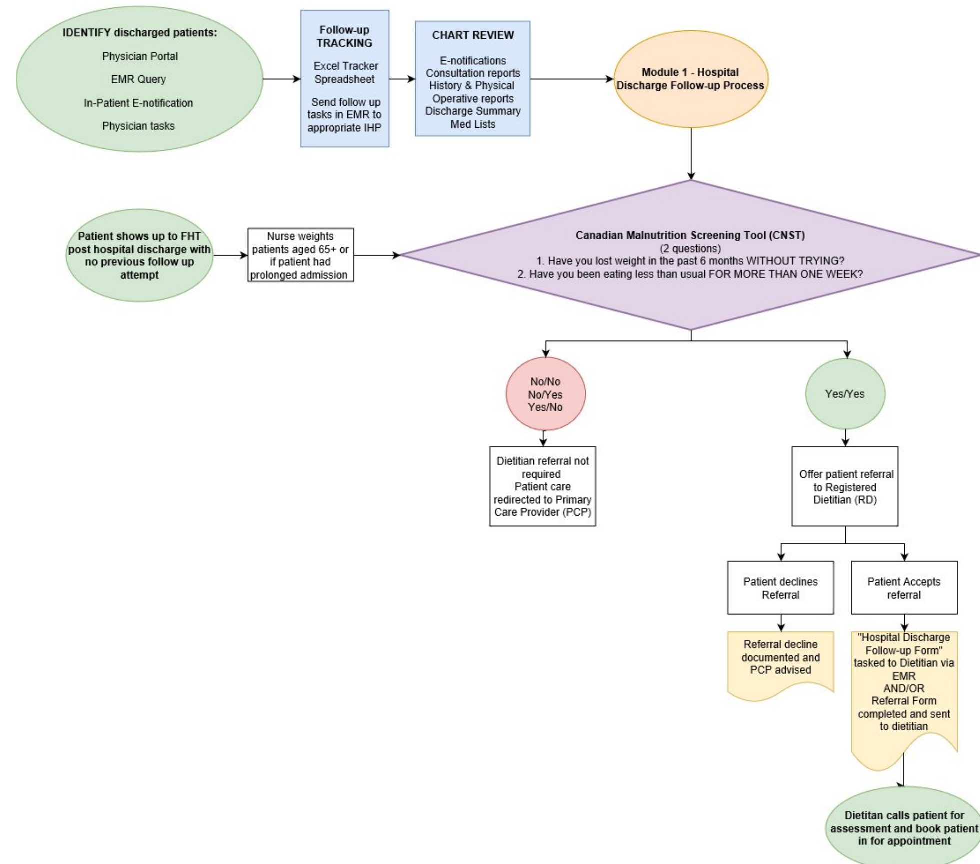
Module 2 – Malnutrition Screening





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Malnutrition Screener in EMR

CANADIAN NUTRITION SCREENING TOOL (CNST)

Name:	Age:	Weight:	Room:
Brice2 (Bricey) Test	55 Yr	120 kg	

Identify patients who are at risk for malnutrition

	Date: 2018-Feb-12		Date: MM/DD/YYYY	
	Admission		Rescreening	
Ask the patient the following questions*	**Yes**	**No**	**Yes**	**No**
Have you lost weight in the past 6 months **WITHOUT TRYING** to lose this weight? If the patient reports a weight loss but gained it back, consider it as NO weight loss.	☐	☐	☐	☐
Have you been eating less than usual **FOR MORE THAN A WEEK**?	☐	☐	☐	☐
Two "YES" answers indicate nutrition risk†				

* If the patient is unable to answer the questions, a knowledgeable informant can be used to obtain the information. If the patient is uncertain regarding weight loss, ask if clothing is now fitting more loosely.

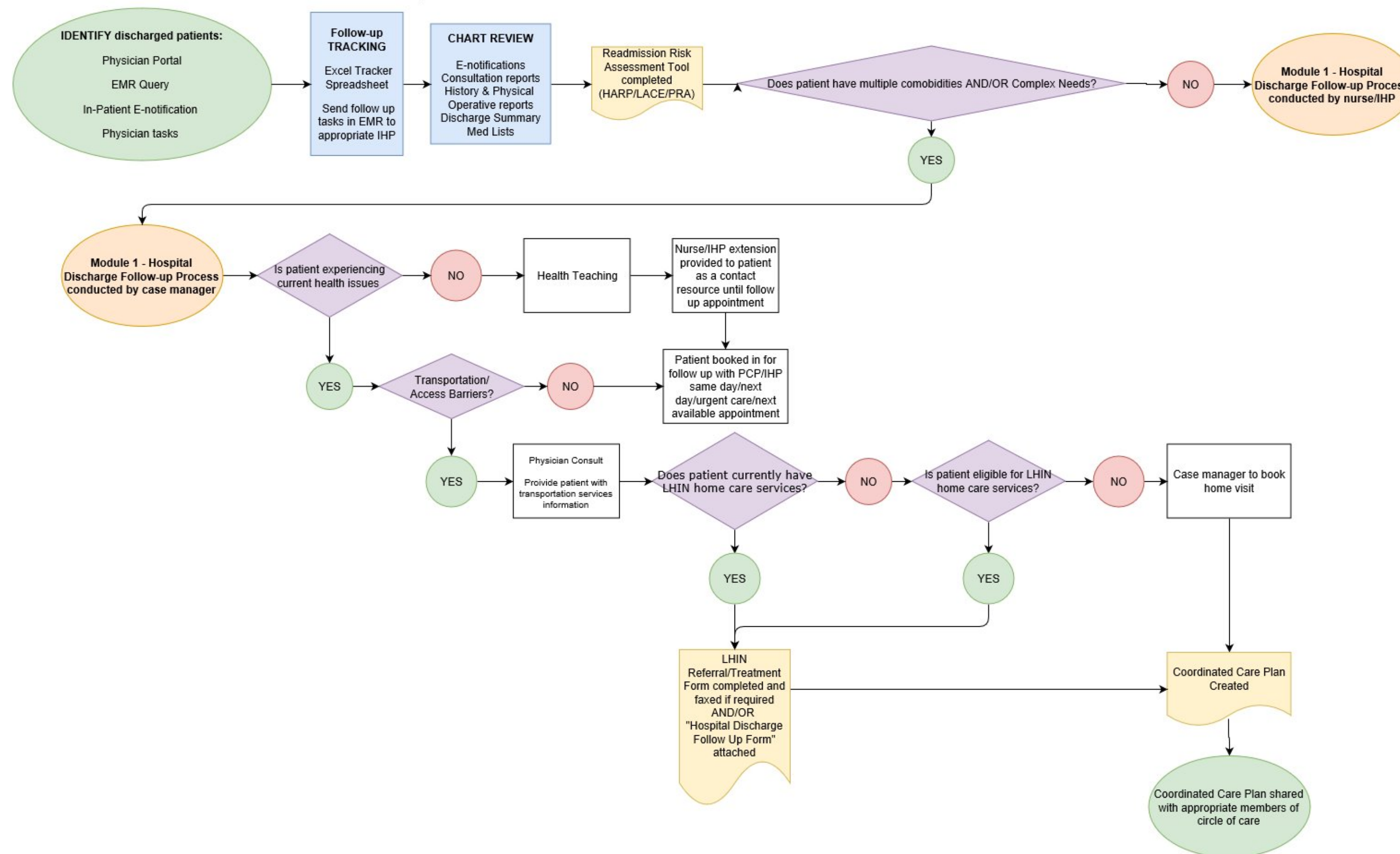
Patients at nutrition risk need an assessment to confirm malnutrition

Nutrition screening using a valid tool can generate a significant volume of requests for nutrition evaluation. Subjective Global Assessment (SGA) is a simple and efficient first-line assessment of nutritional status that can be used following a positive screening and to help prioritize cases.

If a patient is malnourished (SGA B or C), an in-depth nutrition assessment, along with treatment, is required by a registered dietitian.

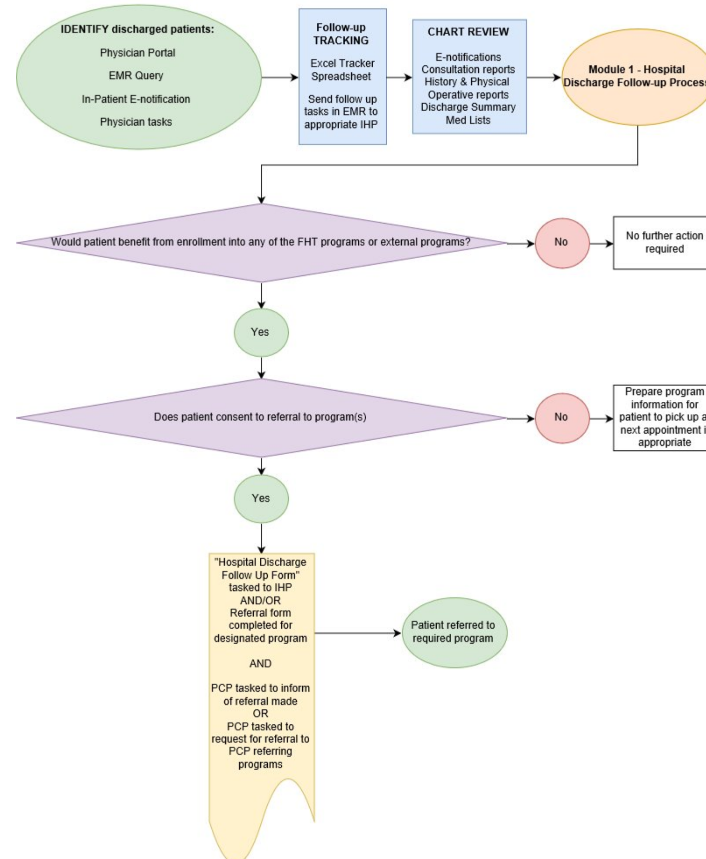
The Canadian Nutrition Screening Tool was rigorously validated and tested for reliability in Canadian

Module 3 : Case Management



1. Assessment and continuity of care
2. Information sharing
3. Coordinated Care plans

Module 4 - Internal/External referrals



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What patients are provided with from discharge to follow up

Health teaching/ Health education

Healthcare navigation

Internal/External program/service navigation and/or referral

Ensure accessibility/transportation

Direct nurse contact during business hours

EMR update

Medication reconciliation (if applicable)

Malnutrition screener

Urgent care hours and utilization reviewed

Reminder to bring medications to appointment

Collaboration among their TDFHT circle of care and sometimes LHIN home care

Immediate needs met

A mode of follow up regardless if they are able to see their PCP

Coordinate all their TDFHT appointments to accommodate accessibility, and effectiveness

What the team is provided with for the follow-up appointment

Overview of patient's current state since being discharged home

Medication list up to date

Awareness of current community services that are part of the patient's circle of care

A more personal view of the patient

Updated diagnostic/ problem list

Surgery/Procedure list up to date

Dates of follow up appointments for referrals made in acute care

One page focused summary of the patient's admission

Ability to focus follow up appointments more on recommendations and patient's requests.

Reduced amount of time searching for pertinent information

Success Stories

"When you called I felt like thank god, someone from the doctors office knows everything that is going on with both of my parents. When you came on board everything fell in place, after the first hospital visit everything was a mess"

-KM

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Thank you

Andrew Atkins aatkins@windsorfht.ca

Diana Nichol dnichol@tdfht.ca

Questions?