Unpacking the Post-discharge or Post-ED Telephone Call

VISN20

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VISN22

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April 18, 2012

PACT
PATIENT ALIGNED CARE TEAM

PACT

The Patient Aligned Care Team

VHA's model of the Medical Home

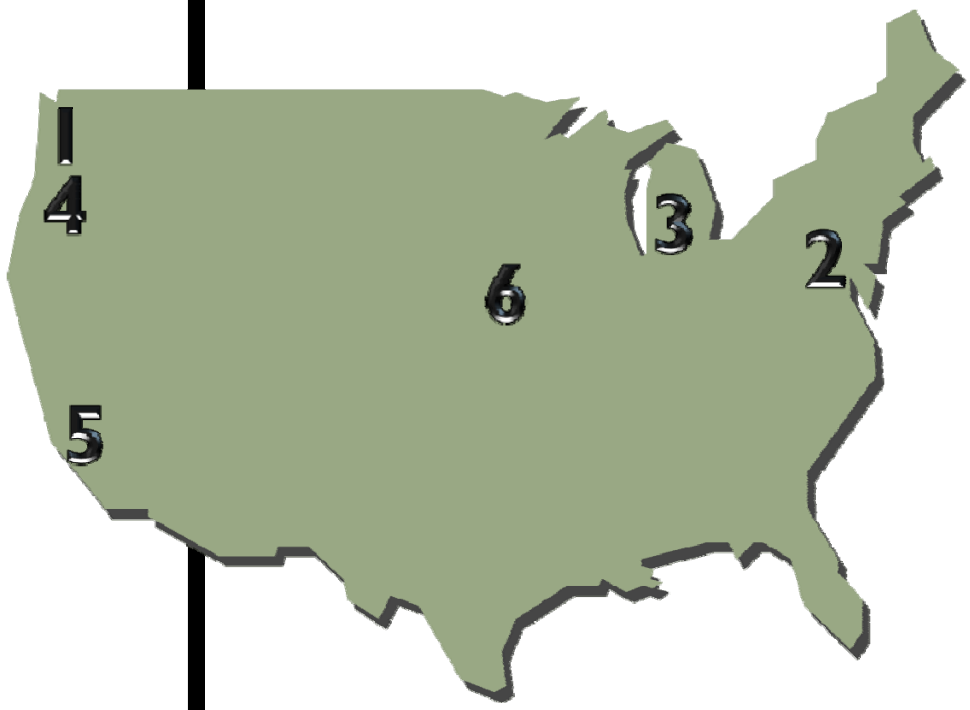
- Each Veteran working together with health care professionals to plan for whole-person care and life-long health and wellness.
  - **P**artnerships with Veterans
  - **A**ccess to care using diverse methods
  - **C**oordinated care among team members
  - **T**eam-based care with Veterans as the center of their PACT

Goal for the Patient's View of PACT

Access	Relationship over time	Comprehensive services	Coordination
• I can get care when and how I need it	• I have a Team who knows me as a person	• My Team takes care of the bulk of my needs	• My Team coordinates any care I need in the health system

PACT Demonstration Laboratories

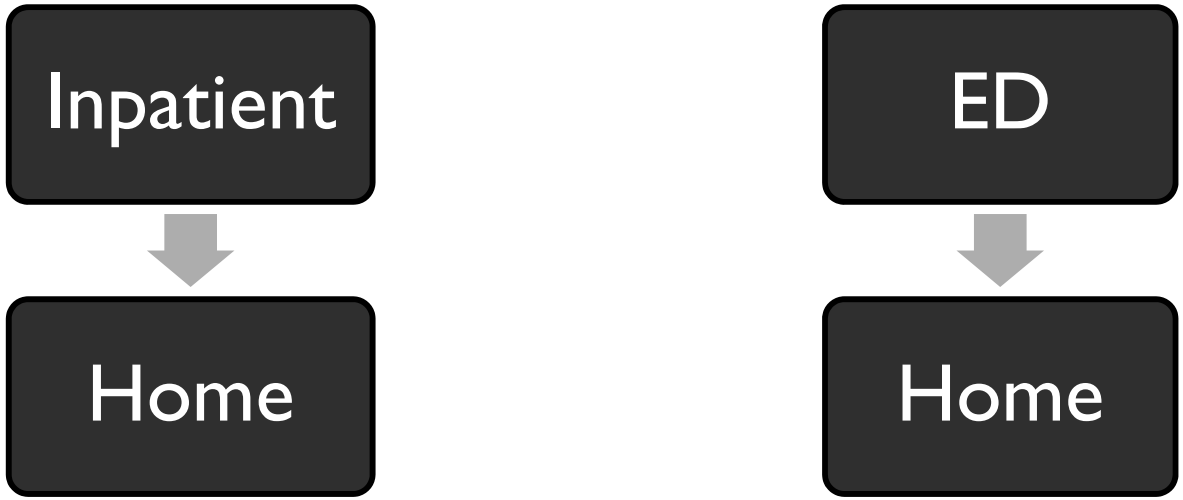
- Evaluate the effectiveness and impact of VHA's PACT model
- Develop and test innovative solutions for the core components of the PACT model



1. **PACT Demonstration Lab Coordinating Center**: Seattle, WA.
2. **VISN 4 Center for Evaluation of PACT (CEPACT):** Philadelphia, PA.
3. **VISN 11 PACT Demonstration Laboratory:** Ann Arbor, MI.
4. **VISN 20 PACT Demonstration Laboratory:** Portland, OR.
5. **VISN 22 Veterans Assessment and Improvement Laboratory (VAIL):** Sepulveda, CA.
6. **VISN 23 PACT Demonstration Laboratory:** Iowa City, IA.

Goal of Today's Presentation

- Describe our experiences with systems to improve the transitions between different sites of care



Transitions in Care

- Potentially problematic
- Associated with Adverse Events
  - Medication Errors *(Forster, 2005)*
  - Missed Test Results *(Roy, 2005)*
- Approximately 1 in 5 patients discharged from the hospital is readmitted within 30 days *(Jencks, 2009)*

Clinical Initiative

- Overarching Goal: Improve the quality of care across transitions

- The postdischarge telephone call is a strategy used for decreasing rehospitalizations. *(Hansen, 2011)*

Portland VA Goal: Increase the percentage of patients contacted after discharge via telephone by Primary Care RNs

Already in place in 2011…

- Patients had telephone appointment made for 3 business days after discharge
  - Calls made by RN associated with their own PACT teamlet
- VISTA emails: back-up system

Already in place…

- Template for telephone call documentation:
  - General assessment
  - Medication reconciliation
  - Pending/needed appointments

- Dedicated note title automatically connected to encounter

What needs to improve?

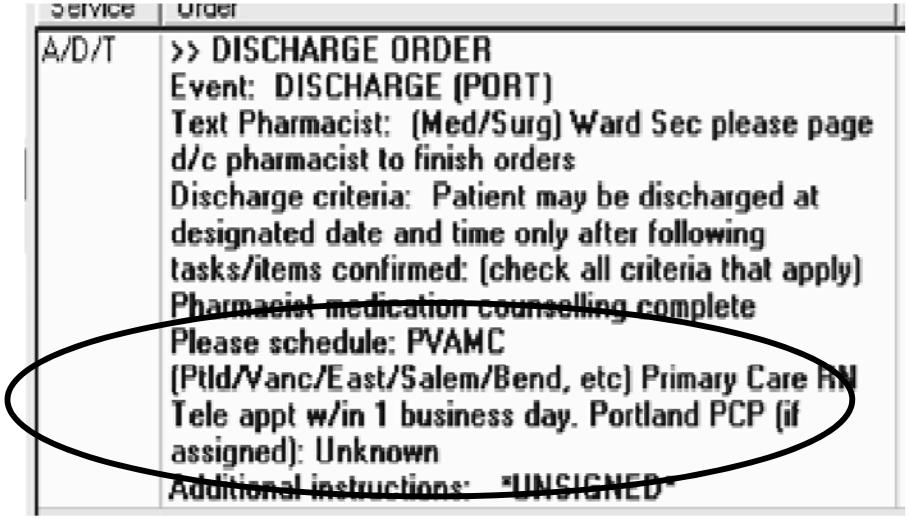
- Process unreliable – reaching 15-20% discharges
- VISTA email fatigue
- Should we contact patients earlier?
- Significant editing of note template

Revised Goal = contact at least 50% of discharging patients by the second business day after discharge

Methods

- RN education for 11 clinics
  - Evidence base regarding transitional care
  - NCM ownership of process
  - Data review
  - Appointments and encounters
- Individual RN champions
- Moved up call to 1 business day after discharge
- Met with multiple stakeholders

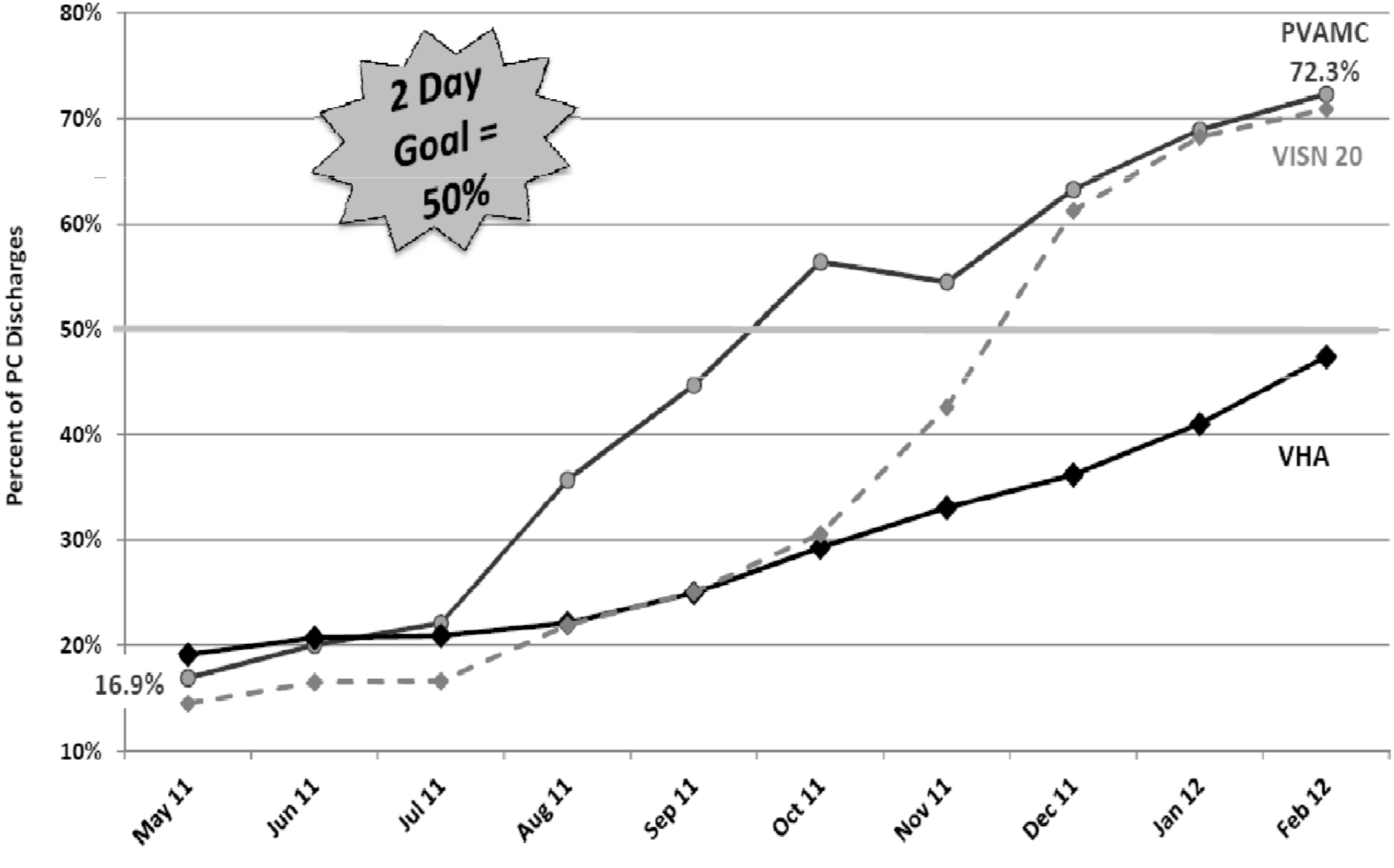
- Worked with Inpatient Ward Secretaries
- Implementation of semi-automated process in CPRS
  - Alert RNs <u>one</u> day after discharge



Service	Order
A/D/T	>> DISCHARGE ORDER Event: DISCHARGE (PORT) Text Pharmacist: (Med/Surg) Ward Sec please page d/c pharmacist to finish orders Discharge criteria: Patient may be discharged at designated date and time only after following tasks/items confirmed: (check all criteria that apply) Pharmacist medication counselling complete Please schedule: PVAMC (Ptld/Vanc/East/Salem/Bend, etc) Primary Care RN Tele appt w/in 1 business day. Portland PCP (if assigned): Unknown Additional instructions: *UNSIGNED*

PVAMC 2 Day Post Discharge Follow Up

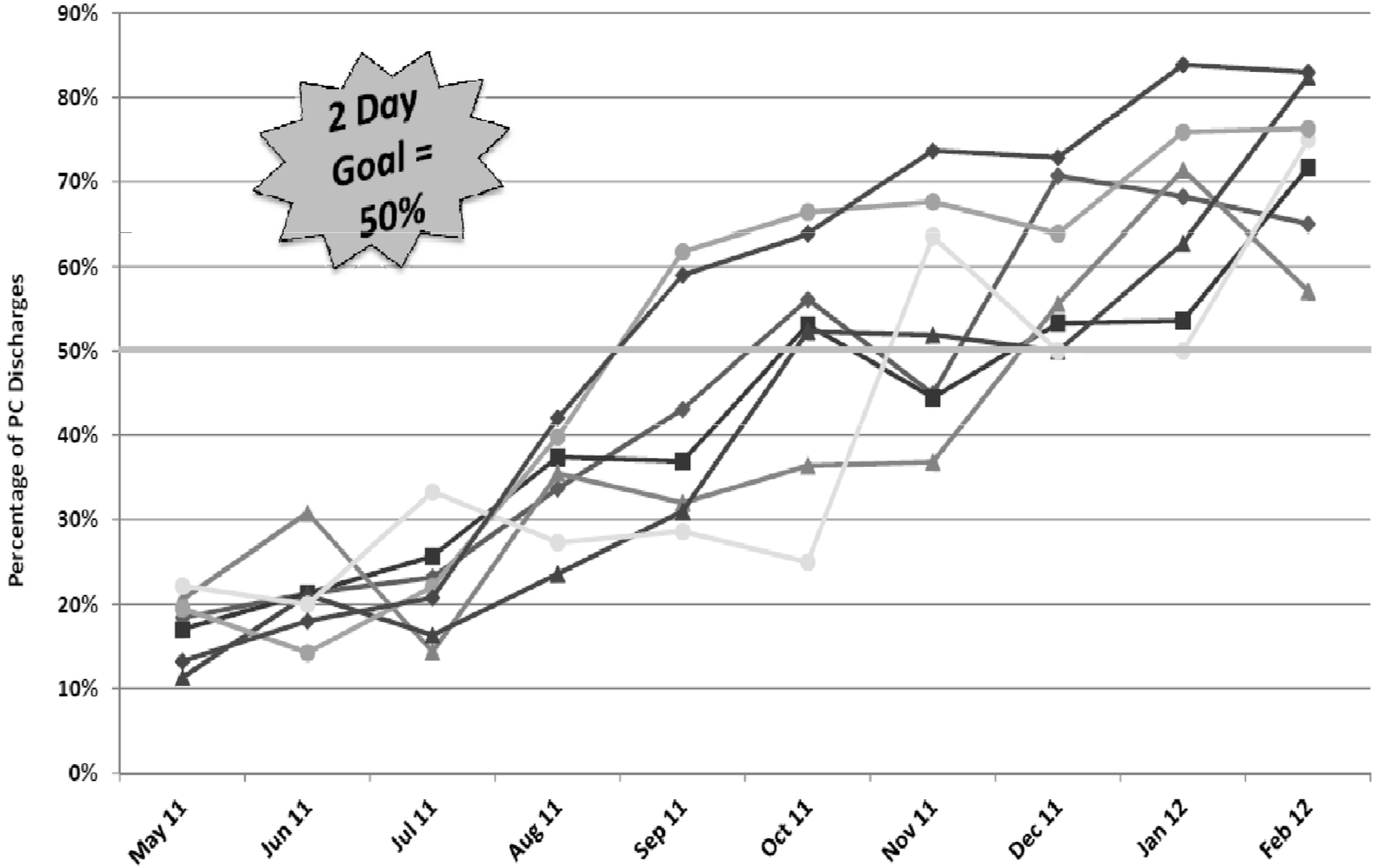
% of Discharges for assigned PC pts where the patient was contacted (either face-to-face or telephone) by PC (incl HBPC) within 2 business days post discharge.
Includes ALL admissions (Deaths and readmissions excluded)



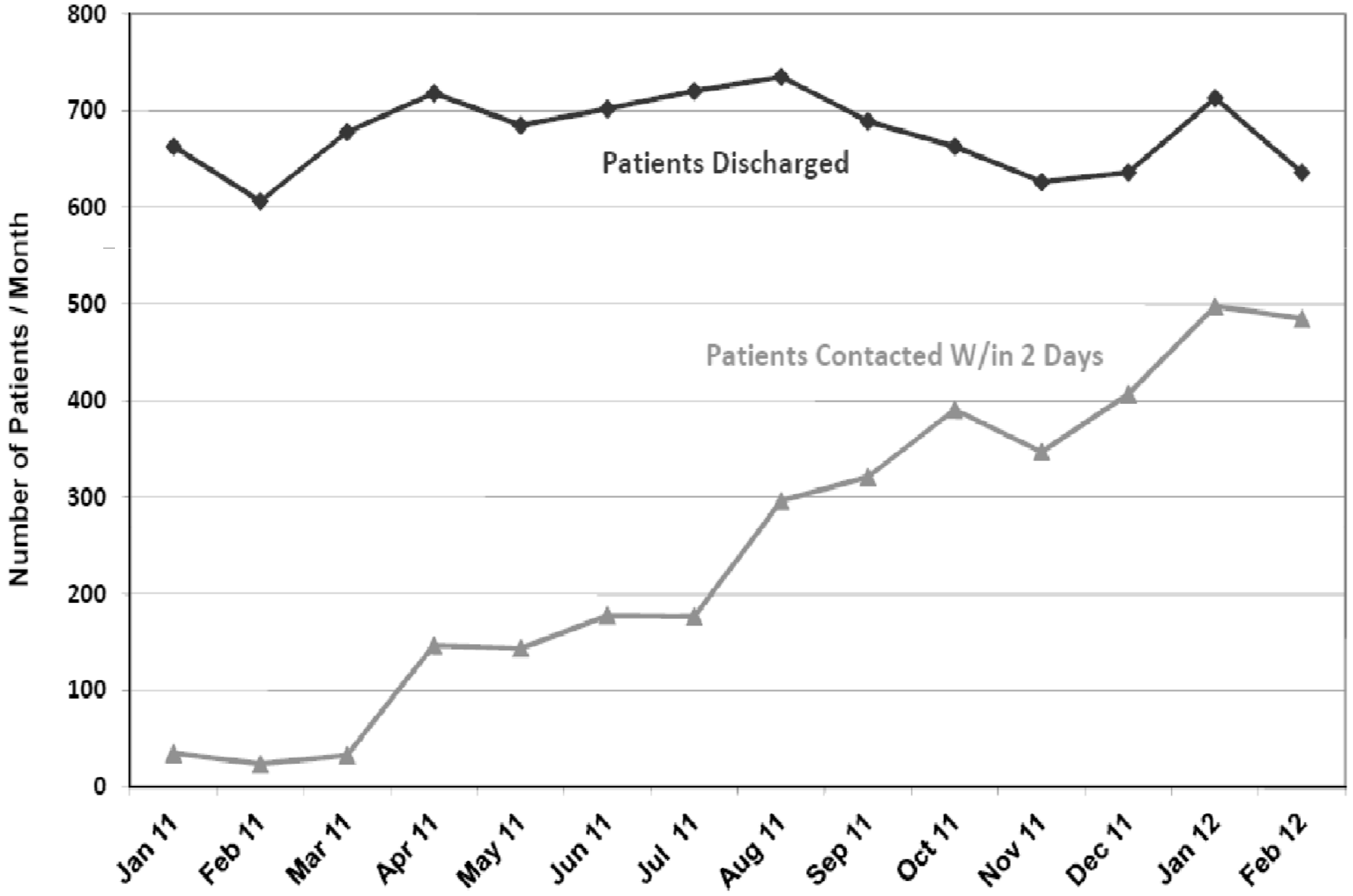
PVAMC 2 Day Post Discharge Follow Up Contact

Clinic/CBOC Level Data

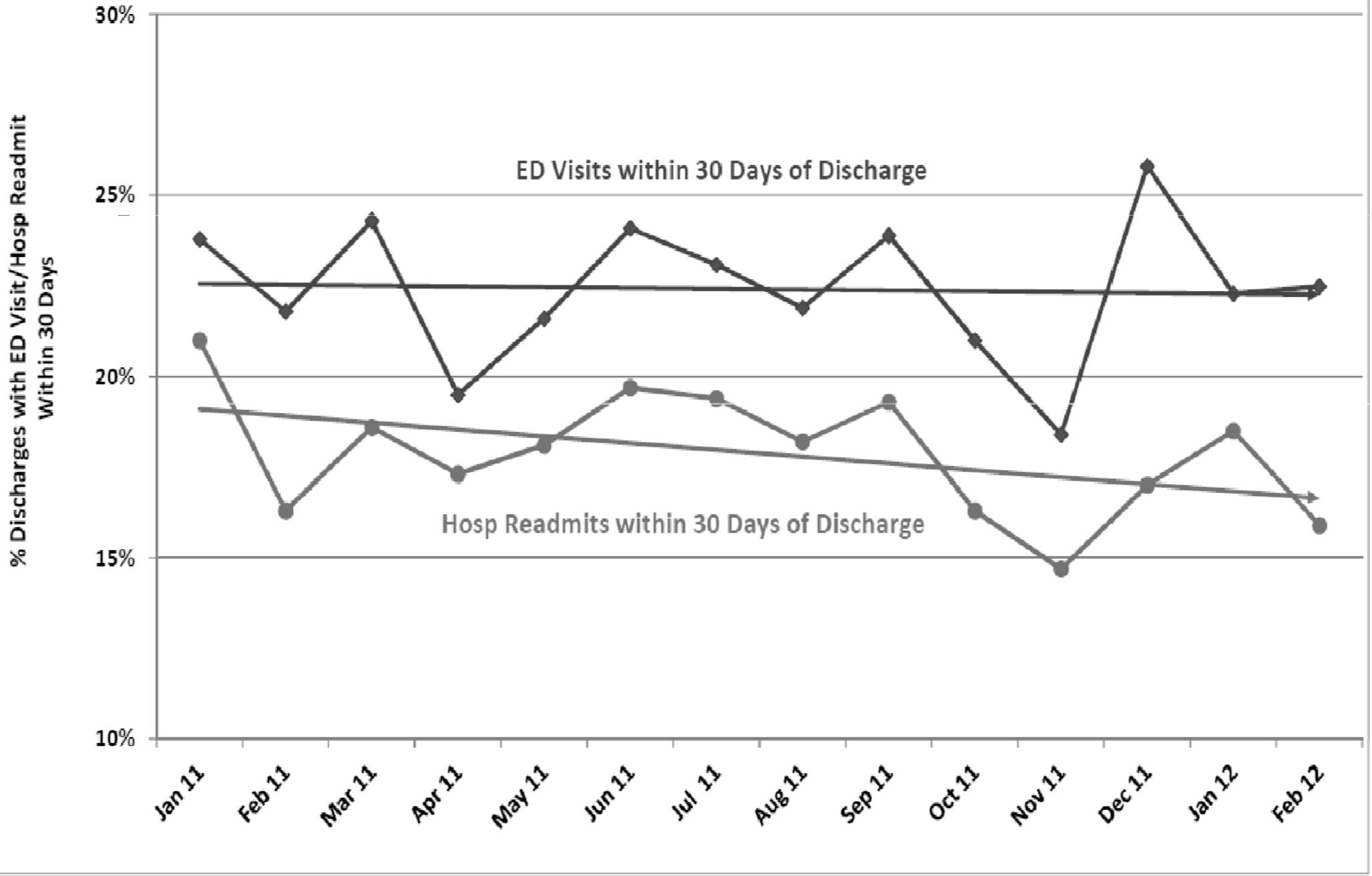
(Data Source: PC PACT Compass)



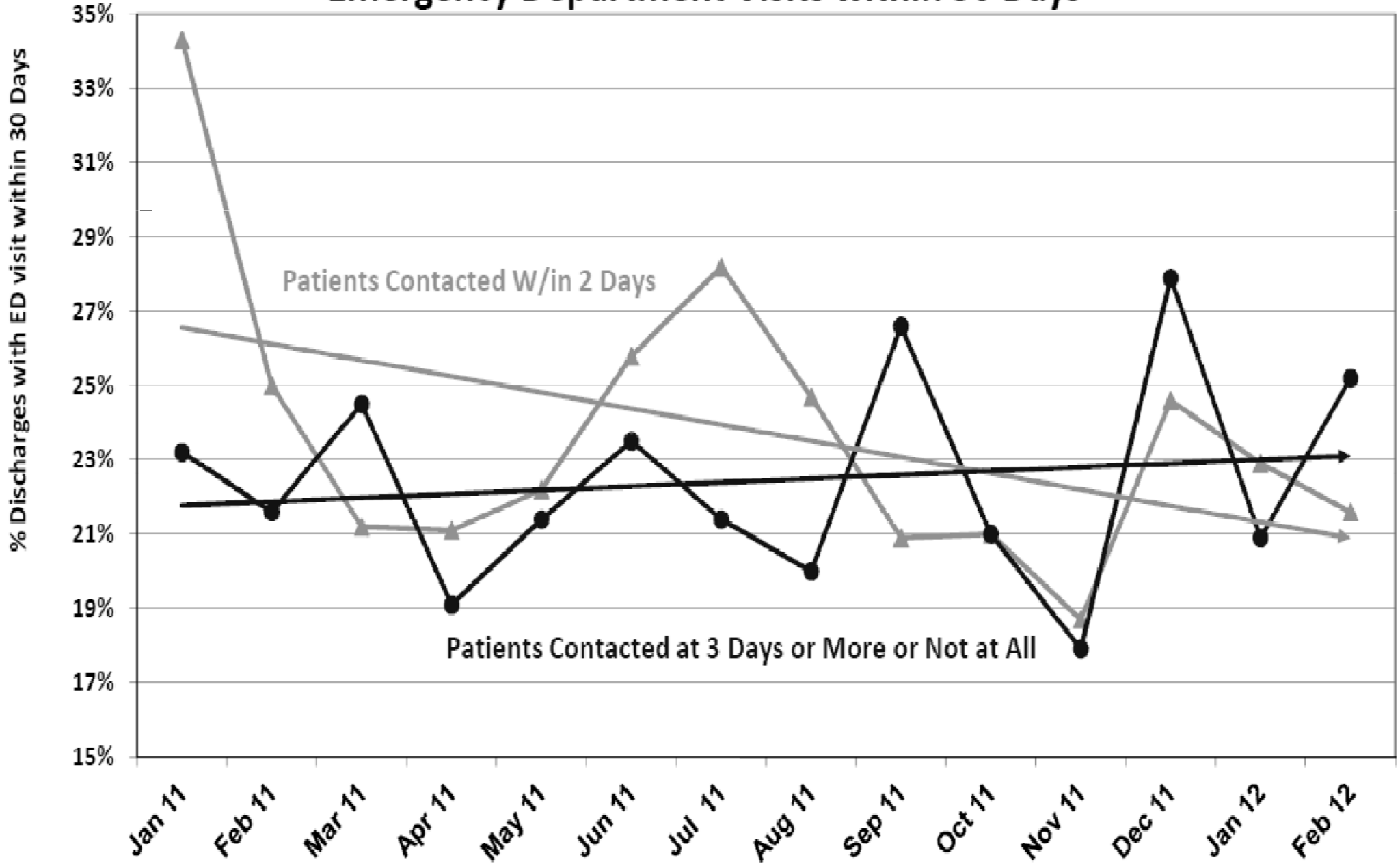
PVAMC Primary Care Patients
Number of Patients Discharged per Month



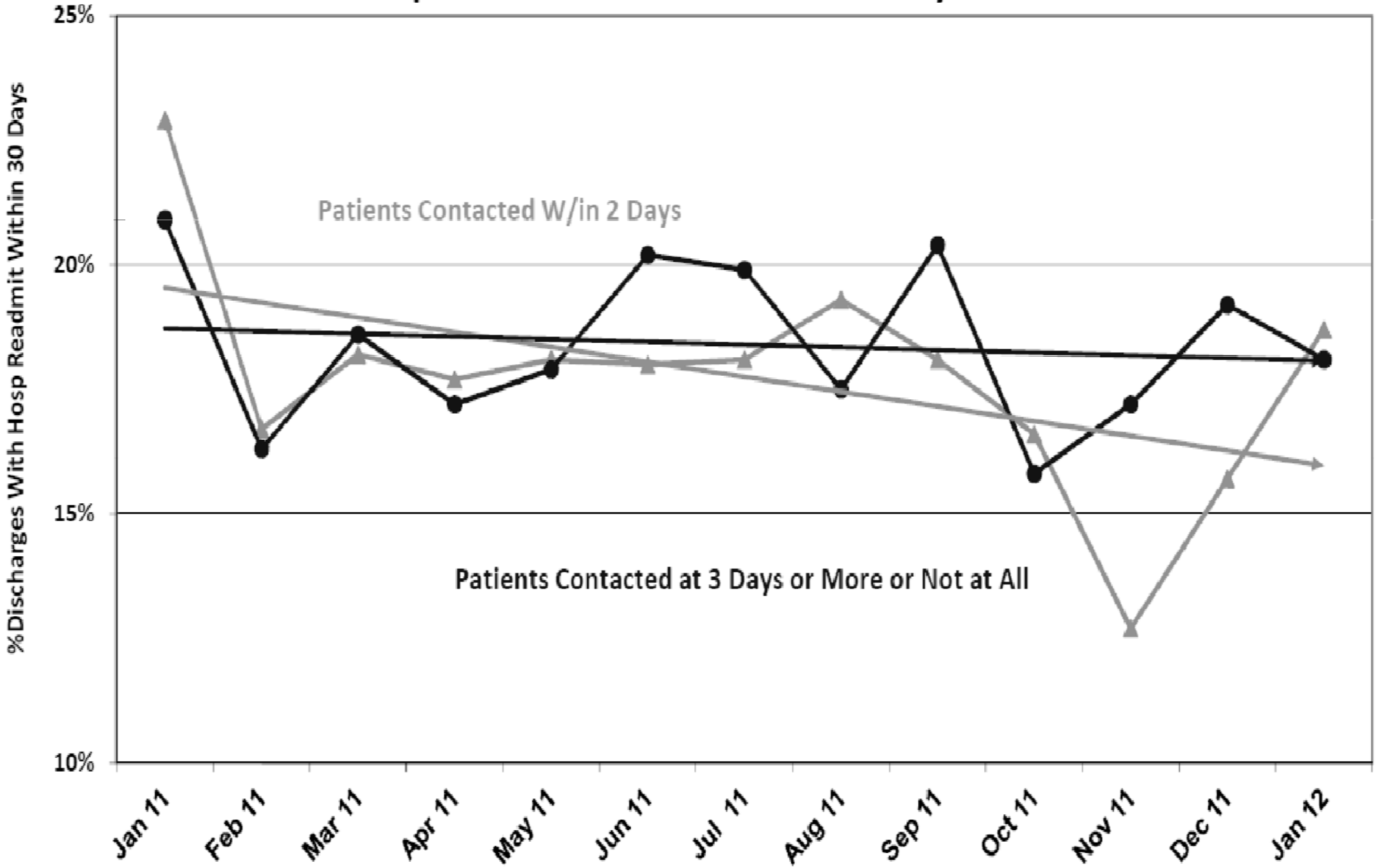
PVAMC Primary Care Patients
Percentage of All Discharges Followed by
ED Visit/Hospital Readmission Within 30 Days



PVAMC Primary Care Patients
Percentage of Discharges with
Emergency Department Visits within 30 Days



PVAMC Primary Care
Percentage of Discharges with
Hospital Readmissions within 30 Days



In Conclusion,

- All clinics reached 2 day goal of at least 50%
- ED visits / Rehospitalizations within 30 days of discharge
  - Downward trend for patients contacted in $\leq$ 2 business days
- Development of policy document
- Revision of RN note template
- Random monthly audits of telephone appointments started Jan 2012

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PACT Follow-Up Care and Coordination After Emergency Department Care – A Pilot Project

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4/17/2012

Today's Presentation

1) **Introduce the problem of inadequate communication and coordination of care post Emergency Department (ED) discharge**

2) **Describe Greater Los Angeles' proof-of-concept pilot innovation for communicating and coordinating post-ED care with PACT teams**

3) **Discuss the potential impact on PACT performance of having a reliable and systematic method of communicating urgent and specific ED follow-up care needs**

Context

- **VAIL uses evidence-based quality improvement methods to support PACT transformation**
  - **Sponsors local Quality Councils that review and support PACT innovations**

- **VAIL identified post-ED communication and coordination with PACT as an area of concern**
  - **Continuity Measure**
  - **Access Measures**

Problem

- **With no systematic and reliable method for communicating and arranging for post-ED follow-up needs:**
  - Patients were often being told by ED clinicians to walk-in to see their PACT providers ↓(*Continuity)*
  - When there was uncertainty about whether the patient could walk-in, they were sometimes being told by ED clinicians to return to ED for follow-up *(↓ Continuity)*
  - Patients were being told to call their PACT teams for an appointment in 2 days as a “safety mechanism” in case their symptoms got worse *(↓ Access)*

My patient -

- An 85 year male Veteran seen in the West Los Angeles ED and diagnosed with pneumonia and a mild CHF exacerbation. He was started on an antibiotic and his diuretic was increased. The ED doctor thought he needed close follow-up . Unsure of whether this patient could get this follow-up in primary care, told the patient to return to the ED in 2-3 days for reassessment.
- 3 days later, his 80 year-old wife drives them 2 hours to return to the ED, and then they wait 2 hours to see me. I walk in the room and ask how he is doing. The wife says “He is much better, his energy and breathing are both better and the swelling in his legs is completely gone.”
- My first thought – <u>this could have been done over the phone</u>

AIM

- **To develop and test, as a proof of concept, a systematic and reliable mechanism for ED providers to communicate with PACT team-members about patients needing urgent or specific follow-up care**
  - *Done as a VAIL Quality Council Innovation Project (Sepulveda Clinic)*

STEP 1: Assessing the Evidence

- **Limited in scope**
- **Some return ED visits, like rehospitalizations, are preventable**
- **About 20-25% of ED patients will return within 30 to 90 days**
- **30 day ED return rate for Sepulveda clinic patients is 20%**

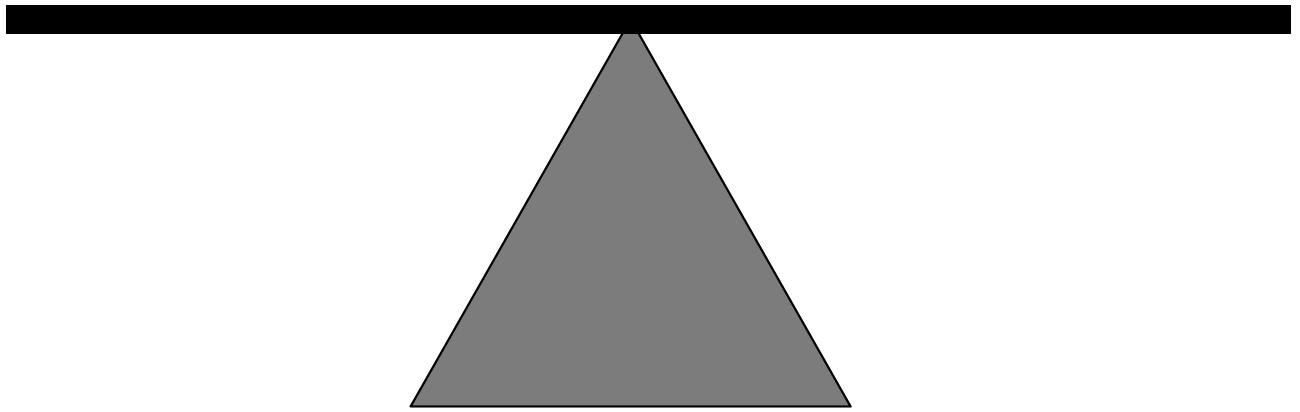
STEP 2 – Forming a multidisciplinary PACT-ED stakeholder workgroup

- **1 Organizer/Facilitator (me)**
- **2 Emergency Department Clinicians**
- **1 Primary Care Physician**
- **1 PACT RN Care Manager**
- **1 PACT Lead Clerk**
- **1 Clinical Applications Coordinator (PharmD with Primary Care Experience)**

STEP 3–Exploring and understanding ED & PACT processes, expectations, frustrations

Need to incorporate communications into ED workflow; multiple part-time providers with high turnover

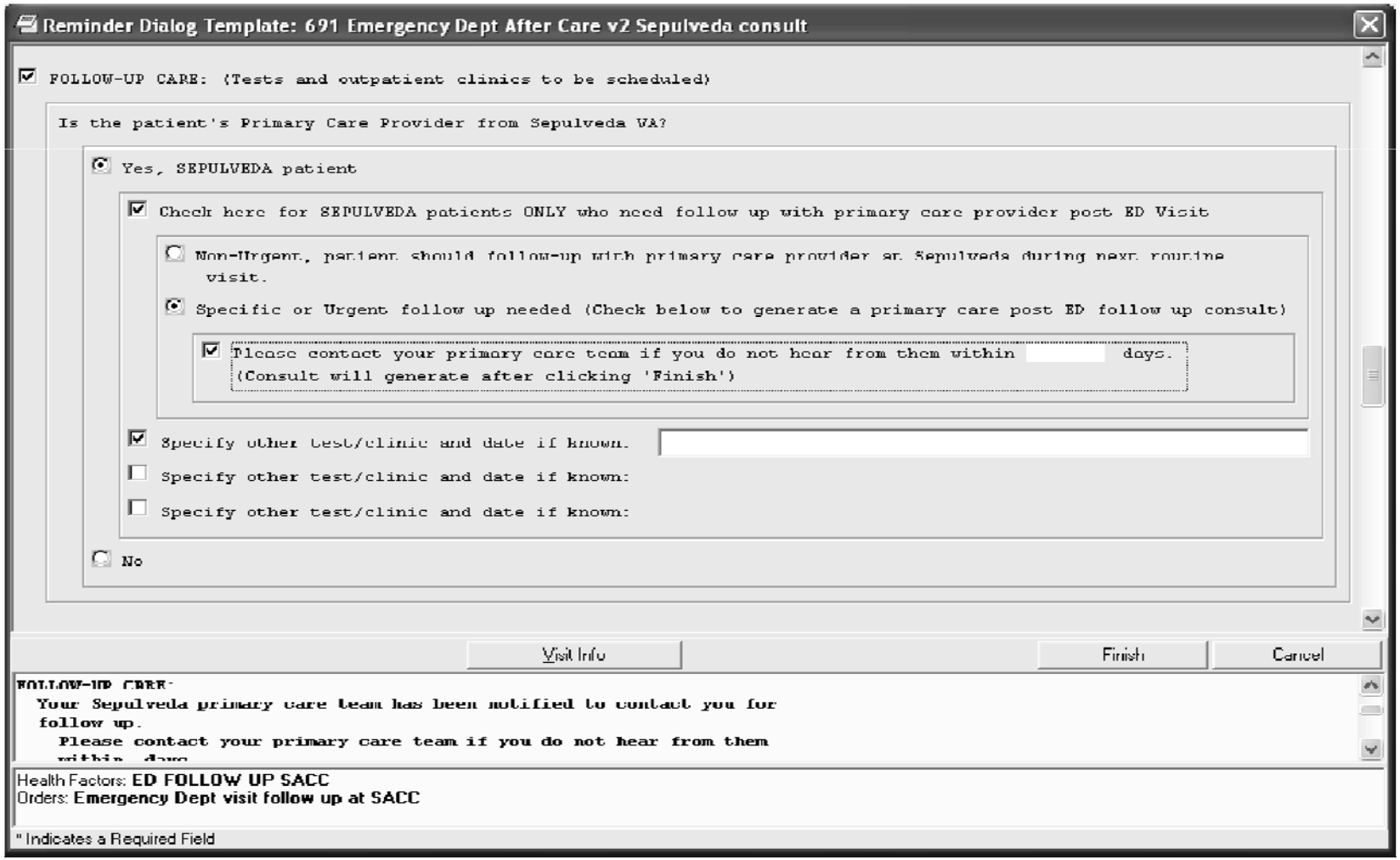
Limits in PACT team time and in-person appt availability



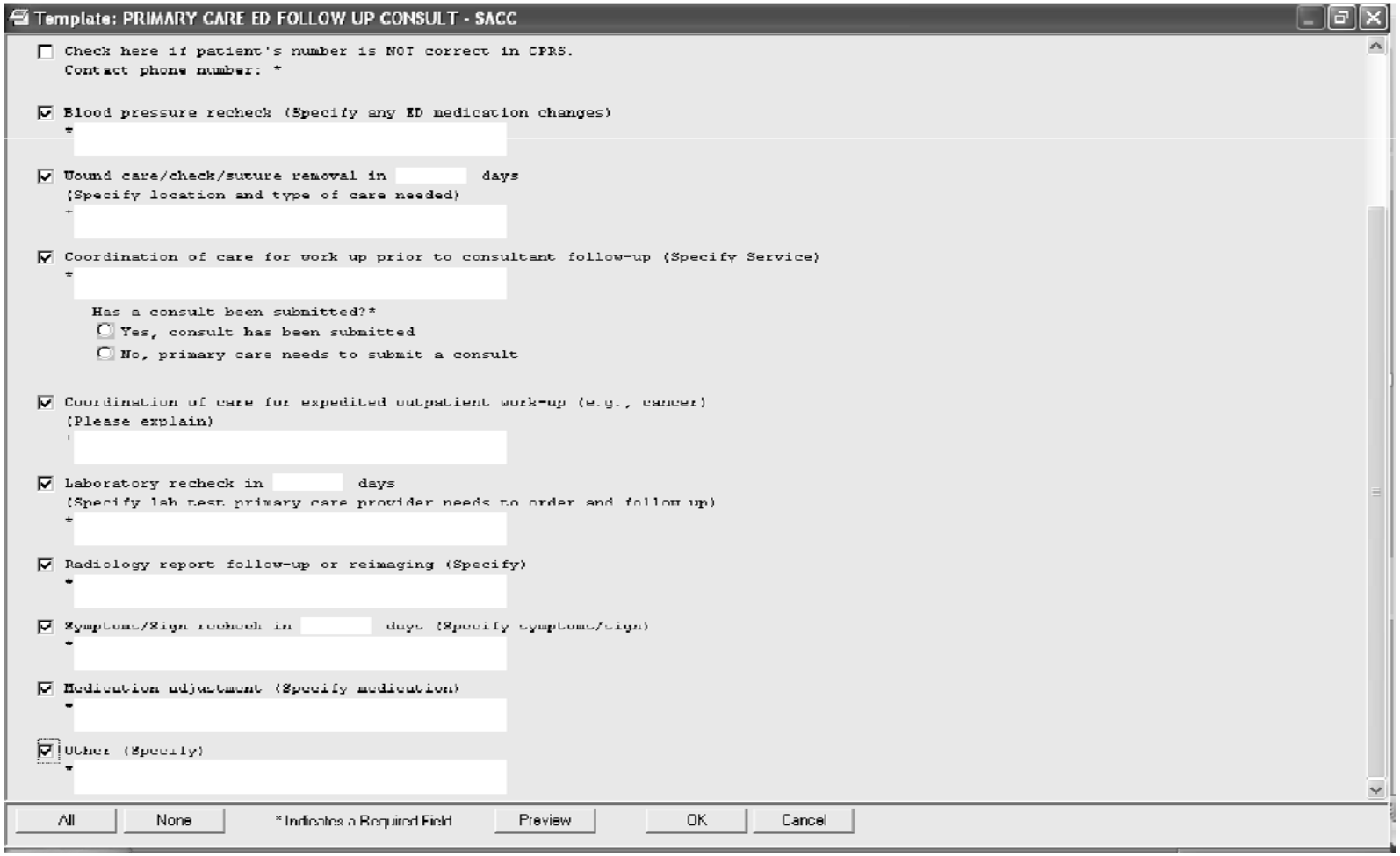
STEP 4- Developing a CPRS Tool

- **Embedded an administrative consult request into the aftercare instructions note that the ED providers fill-in**
- **Templated consult request prompts ED providers to fill in specifics of follow-up care needs**
- **Consult request transmitted to primary care and routed to the PACT RN care manager**
- **PACT RN care manager works with the team to address the follow-up care need as appropriate**
  - **Phone call, nurse visit, PCP visit, etc**
  - **As administrative consult, RN can close consult with a comment**

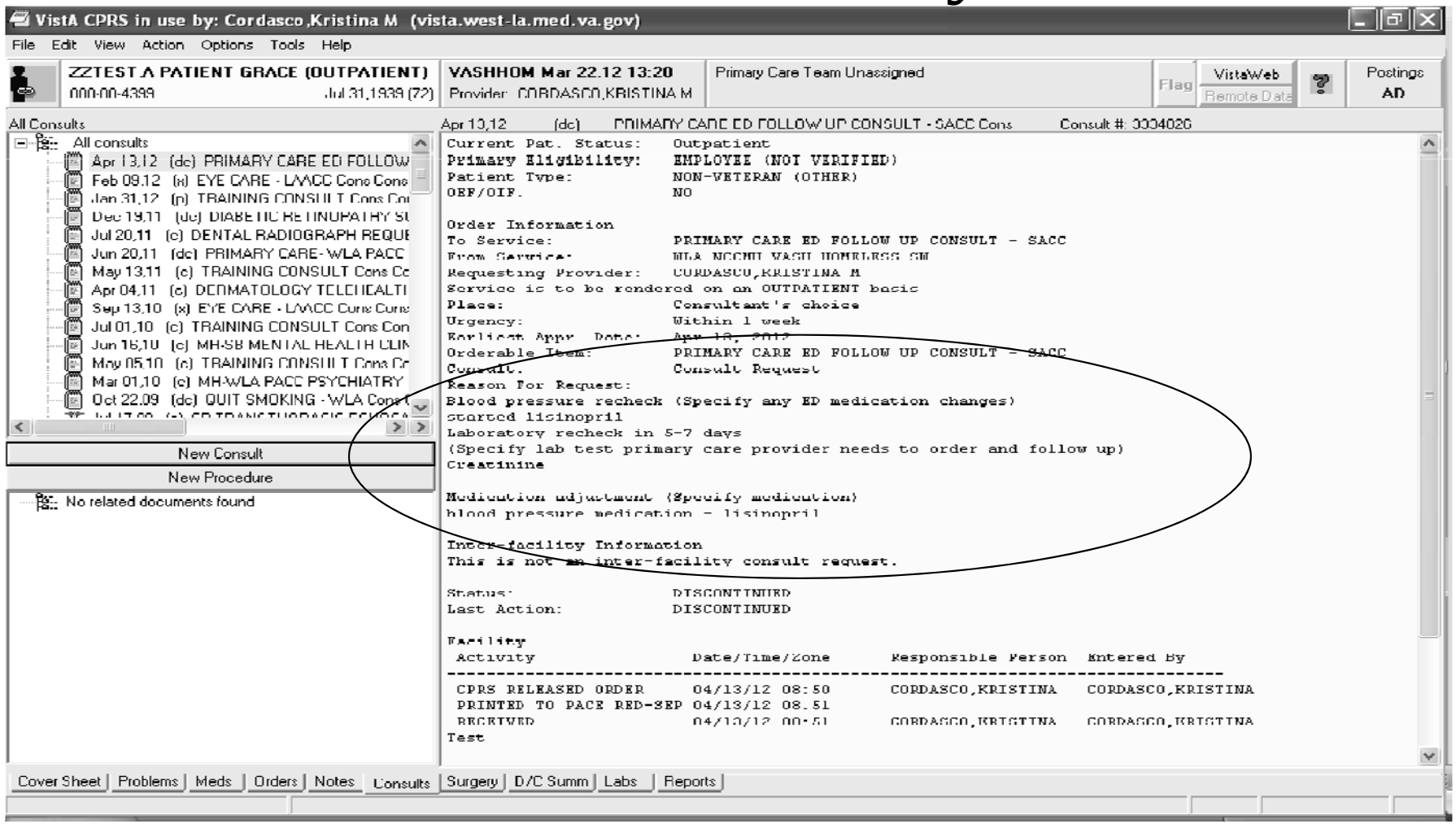
Aftercare Instructions



Templated Consult Request



Consult Received in Primary Care



STEP 5 - PDSA Cycles

- **<u>PDSA cycle 1:</u> ED Provider in workgroup filled in and signed consult for one patient**
- **<u>PDSA cycle 2:</u> Selected ED providers used tool for one team's patients in Sepulveda clinic**
- **<u>PDSA cycle 3:</u> Selected ED providers used tool for two teams' patients in Sepulveda clinic**
- **<u>PDSA cycle 4:</u> All ED providers use tool for all Sepulveda patients**

Example #1 – Sign/Symptom Recheck

- **ED communication: Symptoms/Sign recheck in 2-5 days: redness, swelling, and pain of left thigh**

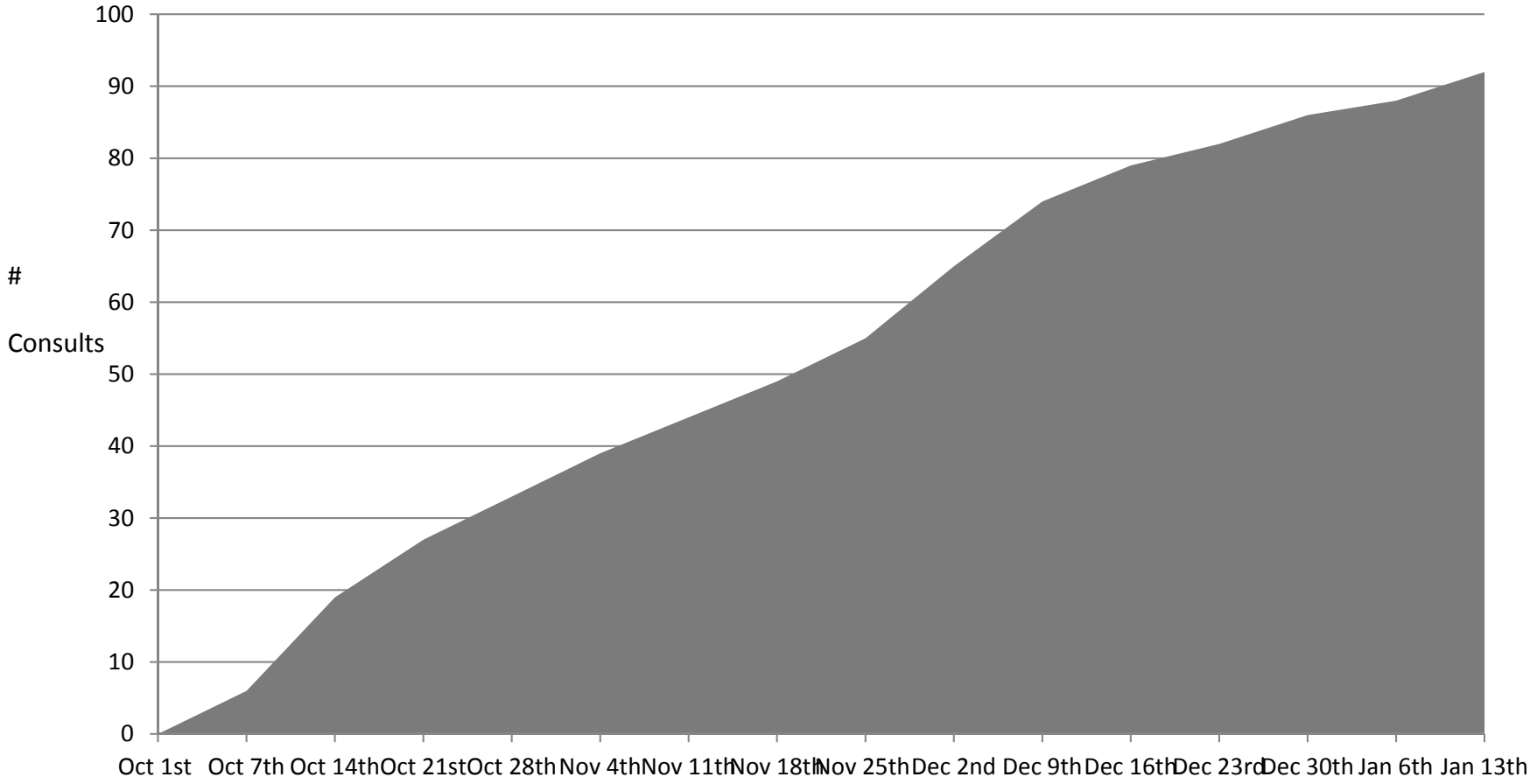
- **RN Care Manager response: "Called pt to f/u on him post ER. He said his L lower leg still appeared red but better, still taking Cephalexin. Informed of f/u appt made 07/12/2011 but he said he did not need it. Advised to call for appt if leg not better or getting worse after antibiotics. Pt agreed with plan"**

Example #2: Care Coordination

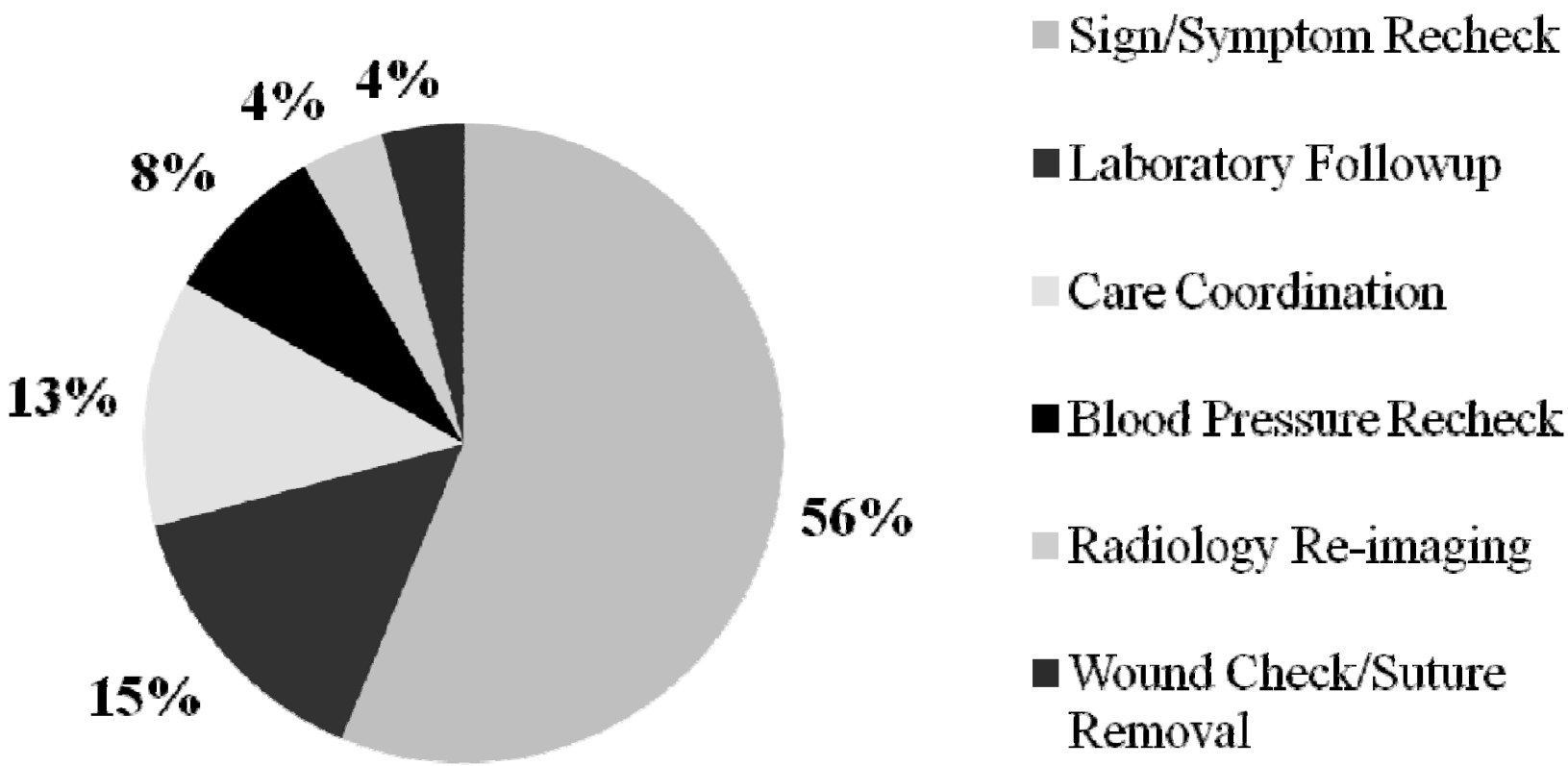
- **ED request: Coordination of care for work up "patient needs transesophageal ECHO and Holter monitor before neuro f/u with Dr. Su, neurology. "**

- **RN Care Manager response: "Echo: Scheduled for 6/23/2011; Holter monitor: 6/30/2011; Neurology: to be scheduled after by service."**

ED Providers Liked and Used Tool



Used For a Variety of Indications



PACT Team Perspectives

- **Useful for preventing walk-ins**
- **Report that patients seem to appreciate that they are being contacted and that the primary care team knows about their ED visit and follow-up needs**
- **RN Care Managers report some difficulty balancing this with other daily work**

Impact on PACT performance measures?

- **Too early to tell… but early indications promising?**

- **Of 16 patients for whom this tool was used in February 2012, 1 had a "walk-in" visit to primary care within 14 days and none had a return ED visit within 30 days**
  - **Overall 30 day return ED visit rate for Sepulveda patients= 20%**

Next Steps

- **Work with newly-formed West Los Angeles Quality Council to expand to the West Los Angeles Clinics**
  - **Continue to refine, adapt, and monitor processe**
  - **Incorporate a Veteran into our workgroup**
- **Continue assessing effects on post-ED walk-ins and ED-revisit rate**
- **If continues to show benefits, VAIL will assist in assembling tool and processes into a package that would enable other healthcare systems to adopt**

VAIL ED-PACT Communications Workgroup Members

Fredalin Braden, RN

Kristina Cordasco, MD, MPH, MSHS

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Tracy Lemle, RN

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Questions/Comments

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4/18/2012	12:00pm	Unpacking the Post-discharge or Post-ED Telephone Call	Patient Aligned Care Teams (PACT) Demonstration Labs	Cordasco, Kristina Richardson, Jenny

Reviewing the trending data for 12 months: Was the n value and in terms of real numbers how many pt admits were avoided?

How does the ED doc identify PACT team when a PC physician is not identified in CPRS or veteran is unassigned?

In Greater Los Angeles PACT team assignment is indicated on the top ribbon of the display for each patient in CPRS (middle of screen and visible when in any tab). On initiation of our project, we did realize many of our ED clinicians did not know that this information was there and therefore we needed to orient the ED clinicians to this. Unfortunately, this pilot currently only works for patients who are assigned to a PACT team, which is a limitation and should be addressed in future work.

Regarding the CPRS note standardization: it would be important to be able to use the notes better in the future, it is important to standardize. Also to remind providers to get full details.

We have a template for hospital discharge follow up that is reflected in the Compass report but we do not have a templated note for ER discharge: Does the compass report reflect ER discharges also?

The compass does not reflect ED discharges. However, ED visits are included in the Compass continuity measure and decreasing ED revisits is an aim of the pilot.

Each provider has an RN care manager-is the ED list populated for each provider CM, or does the CM for the provider populate their own ED list?

There is no populated list of ED patients. Each CM tracks, as needed, the ED patients for whom the CM receives an ED follow-up consultation.

I thought ED phone calls were mandatory regardless (as a performance measure) whether or not a consult is placed??

ED phone calls are not mandatory at this time.

Kristina: are all the ED's using this consult at this time or what is the time frame to start this

This is being done as a pilot in one clinic in Greater Los Angeles Healthcare System. If and when this will be spread to other sites has not been determined, and will depend on our results as we incrementally spread to other clinics and healthcare systems.

4/18/2012	12:00pm	Unpacking the Post-discharge or Post-ED Telephone Call	Patient Aligned Care Teams (PACT) Demonstration Labs	Cordasco, Kristina Richardson, Jenny

If the patient is a Telehealth patient, for example for CHF monitoring and the Telehealth team calls the patient after discharge, does that count toward the measure or does it count against the continuity measure?

The Telephone follow up note template requires an encounter to be completed, however, if there's not patient contact, what note do you use so it does not have to be encountered.

Do you use a Report of Contact rather than an actual 2 day follow up note?

In Fayetteville, AR as long as the patient has a PC team assigned there is a VISTA email that the team gets about the patient being in ER or admitted to our facility.

We could get our ADPAC to share this file report and email generated info?

Now that home Telehealth is embedded in PACT in some VA. Is there a way to integrate HT in the ED/DC follow-up pathway?

We discussed this possibility locally. However, as our ED follow-up program is more than a phone call and the RN Care Manager is triaging the patient's follow-up care needs, in consultation with the PCP when needed, we thought it would be most efficient for the PACT RN Care Manager to do this work directly. However, ideas and testing of other models are certainly welcome.

Does the data for 2 day follow up calls include hospital discharges to patients discharged to other than home i.e. acute care facilities?

Do you find that several consults are placed because as earlier stated follow up in primary care is the standard.

This does occur occasionally, and is dependent on the ED Physician.

It will very helpful if appt with the PACT RN and PACT PCM is added and coordinate since the DH date.

Can you advise how to view the RN modified template from Portland? Interested for CBOC use