H2H2H Change Package Clinic Menu

The purpose of this menu is to assist practices in organizing their improvement activities by grouping some potentially better practices into key focus areas. Review each focus area and consider asking: *What have you already done? Where do you want to start?* Consider mapping out your clinic's journey (see example on page 2)
Options in [hot pink boxes] highlight particularly important potentially better practices.

Pre-Work

Sign up for CII/CPAR

Review and Consider change packages for:
- Panel Processes
- Care Planning
- Access to Continuity

Familiarize yourself with the H2H2H Transitions Guideline

Clinic Foundations

1.1 Establish an inter-professional improvement team and consider including a patient

2.3 Partner with your PCN when you are accepting new patients to your panel

3.4 Develop a process to offer and manage follow up care, as appropriate

3.5 Create a plan for the patient appointment (e.g., medication reconciliation, identification of patient goals, results and outstanding test follow up)

5.1 Establish clear roles and responsibilities for supporting patients in transitions

Care Coordination in Hospital

2.1 Upon receipt of admit notification, develop a process to provide hospital team with any relevant patient information

2.2 Develop a process to identify patients discharged from hospital **(CII/CPAR)**

4.1 Standardize entry of admit notifications, discharge notifications, and discharge summaries

6.1 Communicate as needed post-transition with care providers outside of the medical home

PMH Processes after Hospital discharge

1.2 When appropriate, invite patients to bring a caregiver or family member to a follow-up appointment

3.1 Develop a process to review patient discharge summary from hospital

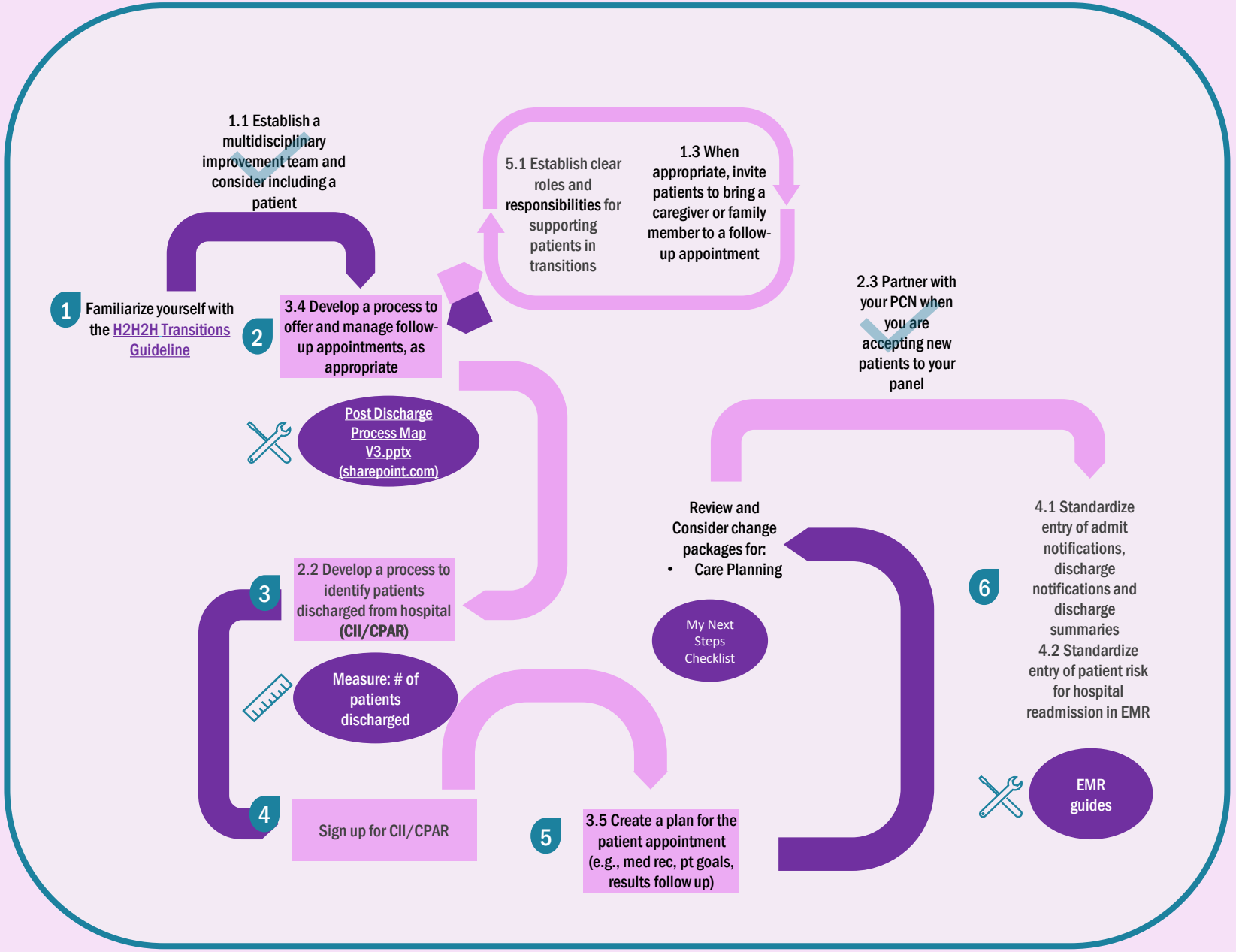
4.2 Standardize entry of patient risk for hospital readmission in EMR

3.2 Develop a process to check each discharge summary for a risk of readmission score

3.3 If a risk of readmission score has not been provided by acute care, develop a process to determine who your high-risk patients are

CLINIC JOURNEY EXAMPLE

Blue Meadows clinic is exploring the H2H2H change package. They have heard about CII/CPAR but have not yet signed up.



1

Blue Meadows begins by reading the Guideline. They have a regular QI team, with a patient representative and decide this is the same team that will support H2H2H.

2

The team starts with standardizing post-hospital discharge follow-up appointments. Through use of process mapping, they establish a process. This involved looking at team roles and responsibilities and inviting patients to include a family member or caregiver.

3

The team realized they may not be identifying all the patients discharged from hospital in a timely way. They monitor their faxes and incoming discharge summaries and track how many patients are discharged in a given 48-hour period.

4

They decide that signing up for CII/CPAR will help them better identify patients admitted and discharged from hospital through e-notifications.

5

When they are able to identify the # of patients requiring follow-up appointments, Blue Meadows decides to focus on implementing care planning strategies and ensuring patient appointments include medication reconciliation, identification of patient goals and outstanding results/test follow up.

6

Finally, Blue Meadows decides to take a look at their EMR processes to ensure that everything is being documented in a standard way.