Healthquest EMR Guide for Home to Hospital to Home Transitions

Reviewed in 2023

Accelerating Change Transformation Team

ACTT

Contents

EMR Advice to Potentially Better Practices

The following are organized by Potentially Better Practices (PBP) and their Process Measures outlined in the H2H2H Transitions Change Package Summary where EMR may be of assistance. For more rationale on the PBP refer to the *Evidence and Rationale*. For an additional list of measures and examples, refer to the *Measurement Guide*.

Taking the time to establish these EMR practices will build transferable skills and capacity. Additional information about the technical enabler can be found on the CII/CPAR web page.

Standardized Text

Wherever possible teams should use standardized text or drop down (e.g., Worklist Tasks). This may take include Auto Completes or Macros which specify standardized text that can be dropped into free text fields. For more information about how to use Auto Completes or Macros in Healthquest see the online help files (e.g., F1 while using Healthquest).

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

If information is shared with the hospital team, ensure that it is recorded in the EMR. This includes who, when, what was shared and outcome of the call. Use searchable terms. You should have a discussion in advance with your physician and team about what information is appropriate to send to the hospital without patient consent.

A common way to do this in Healthquest is to record the exchange of information in a **Care Coordination Worklist**. Using a worklist template created for the purpose of instructing staff to share specific information with the hospital upon admission guides the team in doing this work and allows for it to be monitored until complete. Possible text for the task is **Share Information with Hospital**.

Example Care Coordination Worklist for sharing information with hospital upon admission.

Note: It is recommended that the clinic team review their naming and processes for home to hospital to home Worklist Tasks. The team should review their **Worklist Setup** of Tasks, as the tasks, description and **notes contain** fields are searchable in CDS Queries. The description and/or task names should provide clear instructions and be different for the various processes in this document: sharing information from the home clinic to hospital upon admission, determining the LACE score of patients post-discharge where acute care did not provide a score and follow-up for patients post-discharge.

Process Measure 2.2: Process exists for identifying patients discharged

Process measure 2.2 is a proposed process measure for PBP 2.2. When patients are discharged from the hospital, eNotifications are automated messages delivered directly into the physician's Electronic Medical Record (EMR), with key healthcare information. When a clinic receives information that a patient has had a visit to an emergency department or a hospital discharge, the clinic is to have a process to understand the procedures to identify when patients are discharged.

The EMR activities for this process are very similar to those for **Potentially Better Practice 4.1**. Please see *Using Healthquest to Manage Incoming Admission & Discharge Notifications* in the Potentially Better Practice 4.1 section below.

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

Document all patient communication in the chart – who, when, outcome. The task to do the patient communication can be a Worklist Task for Post-discharge follow-up, for example.

Creating a **Worklist Template** can make data entry more efficient. Add a field for recording the LACE readmission index score or, if a risk score has not been provided on the discharge summary, an in-clinic calculated risk score of readmission.

Recording the risk of readmission in a way that is searchable in Healthquest is important because the goal is to be able to generate a list of patients at high risk for readmission for 4.1 and 4.2 below.

If the readmission risk score (LACE score) is not provided on the report from acute care and a team member is tasked with determining the risk, a **templated Worklist task** to a team member, such as a nurse, would guide that work.

Example of a worklist task to **Calculate the Readmission Risk** of a discharged patient.

Once the readmission risk score is calculated in clinic, it should be added to the **Notes** in the worklist task as this is a searchable field in CDS queries.

> **TIP:** For more information on how to create Worklist templates in Healthquest please refer to the Healthquest Online Help (F1) called **Adding/Editing Worklist Templates.**

Potentially Better Practice 3.4: Develop a process to offer and manage follow-up care, as appropriate

Recording the offer of a follow-up appointment

It is recommended that you record whether a follow-up visit is accepted and booked. A **Worklist template** for post-discharge follow-up task should be created to record if the patient accepted the offer of follow-up, declined, was unreachable or had no follow-up required. It is important to add the LACE risk score to this task as this will be the method to search for patients at high risk for process measures 4.1, 4.2 and 6.1.

> **Note on Alternative Method of Recording the LACE Score for hospital readmission:** If a clinic team is familiar with and has common clinic workflows around manual lab results, creating a manual lab entry for the LACE score is an alternative method of recording this result instead of the worklist entry. Lab results are searchable in CDS Queries. Use CDS Query Setup to build queries around a manual lab result instead of a Worklist task.

Creating follow-up appointments

The clinic team contacts the patient to book an appointment and records the outcome in the Worklist. If the team is able to reach the patient and book an appointment, the details are recorded in the **Appointment** window.

It is recommended that the clinic create an appointment type for hospital discharge follow up. This will allow the clinic to differentiate these types of appointments for future quality improvement activities. A single appointment type for **Hospital Discharge** may be sufficient, or you may prefer to be more detailed

and differentiate between different types of follow up appointments. See the table below for possible appointment types to use for different types of discharge notifications.

Possible Discharge Notification Appointment Reasons:

Type of eNotification	Suggested Appointment Reason
1. Hospital Discharge (recommended)	Post-discharge FU
2. Emergency Room Discharge	ER Discharge FU
3. Day Surgery Discharge	Day Surg Discharge FU

Example:

The type of appointment will display in the schedule for the provider and notes can be viewed while hovering.

Potentially Better Practice 4.1: Standardize entry of admit notifications, discharge notifications, and discharge summaries

How are admission and discharge notifications received in the EMR?

Admission and discharge notifications are sent to clinics either as CII/CPAR eNotifications, [Connect Care Summative Notes](#), or by fax:

1. **eNotifications:** Providers participating in CII/CPAR receive eNotifications, which are automated messages delivered directly into the physician's EMR. eNotifications provide physicians with information about key healthcare events for their CPAR-paneled patients, including emergency room discharges, hospital admissions or discharges and day surgery discharges. eNotifications can be received in the EMR daily at 6 a.m. and similar to electronic lab reports.

   Note that eNotifications about a patient are only sent to the provider who is identified as that patient's primary provider in CPAR. If a patient is paneled to more than one provider in CPAR, an eNotification will be sent to each of those providers. For providers working at different locations, eNotifications are sent to the location where each patient's panel is maintained and submitted to CPAR.

2. **Connect Care Summative Notes:** Connect Care Summative Notes are delivered electronically via eDelivery to the primary care provider (PCP) **identified by the patient** on admission to a **Connect Care enabled site**. They include:
   a. Specialty Consult Findings and Recommendations.
   b. Patient Discharge Summary.

c. Emergency Department Provider's Notes.
d. Post- Operative Notes.
e. Labour and Delivery Notes.
f. History and Physical.

For additional information on Connect Care Summative Notes, please see the following resources:

- [Summative Notes Electronic Delivery to Physician Electronic Medical Records](#)
- [Clinical Documentation to be Made Available from AHS to Primary Care Providers](#)

Note that the criteria for receipt of Summative Notes and eNotifications are different. As a result:

If a patient goes to an AHS facility on Connect Care:
- The CPAR provider receives an eNotification via CII.
- The patient identified PCP receives summative notes via eDelivery.
- **The patient identified PCP *may or may not* be the CPAR primary provider.**
  So:
  - If the patient and CPAR PCP are the same, the PCP gets both notifications.
  - If the patient and CPAR PCP are different, then they each get one notification.

If a patient goes to AHS facility on a legacy system:
- CPAR primary provider would receive notice of:
  - ED discharge.
  - Inpatient admission and discharge.
  - Day surgery discharge.
- No summative notes documents are routed via eDelivery because the facility is not yet on Connect Care.

3. **Faxed Notifications**: Faxed notifications are available in some regions and may be received as an e-fax or as a paper fax.

Note: depending on circumstances providers may receive a combination of eNotifications, Connect Care Summative Notes, and/or faxed notifications.

Using Healthquest to manage incoming admission and discharge notifications

Recommended Method: CII eNotifications, Connect Care Summative Notes of a Patient Discharge Summary and faxed hospital admission and discharge notifications should be recorded in Healthquest as a Worklist Task of **Post-discharge pt follow-up**. That way a clinic can easily identify patients with a notification received in the last 48 hours and complete any necessary steps.

Upon receipt of the notice in the provider's communication window in either Lab Results or Documents, creating the Worklist Task allows the tracking of discharge and follow-up.

Potentially Better Practice 4.2: Standardize entry of patient risk for hospital readmission in patient record

Patient risk of readmission assessment

Before a patient is discharged from hospital, it is recommended that the acute care team complete a patient risk of readmission assessment to identify the patient's risk of readmission. The completed risk of readmission assessment should then be sent to the patient's primary care provider. The primary care provider's clinic should then record the assessment result in their EMR as suggested in the **Recording the Assessment Tool Results** section.

Once approach would be to use:
- Patient LACE Score Low.
- Patient LACE Score Medium.
- Patient LACE Score High.

The EMR activities for this section are aligned with the recommendations for Potentially Better Practice 3.3. Please see that section for details.

Process Measure 4.1 and 4.2: #/% of discharged patients with risk assessment documented in the patient record

PBP 4.1 and 4.2 have a Process Measure that measures patterns and trends of how well a clinic is performing documenting risk of readmission assessment in the patient record. Understanding this performance can assist the clinic to improve on certain activities to improve the standardized entry of patients with risk of readmission assessments.

Start by determining your baseline to understand your current state by documenting patient risk of readmission assessment in the patient record. Determine an appropriate measurement interval (e.g., daily, weekly, monthly) and plot results to calculate a percentage: count ÷ total count.

Example measurement type: Methodology using ratio calculation

$$\frac{\text{the \# of patients with risk of readmission assessment documented in the patient record}}{\text{the total \# of discharged patients}} \times 100 = \text{\% of discharged patients with risk of readmission assessment documented in the patient record}$$

Saving this data to compare it with the next month for data analysis can assist the clinic to improve on documenting risk of readmission assessments in the patient record. Leverage measurement skills from your practice facilitator, if possible.

Finding the numerator and denominator for this calculation will require two different queries in Healthquest:

Numerator

To find the numerator it will be necessary to find the **number of discharged patients who had a risk of readmission score recorded**. The search might look something like this if risk readmission score is recorded in the post discharge follow-up task:
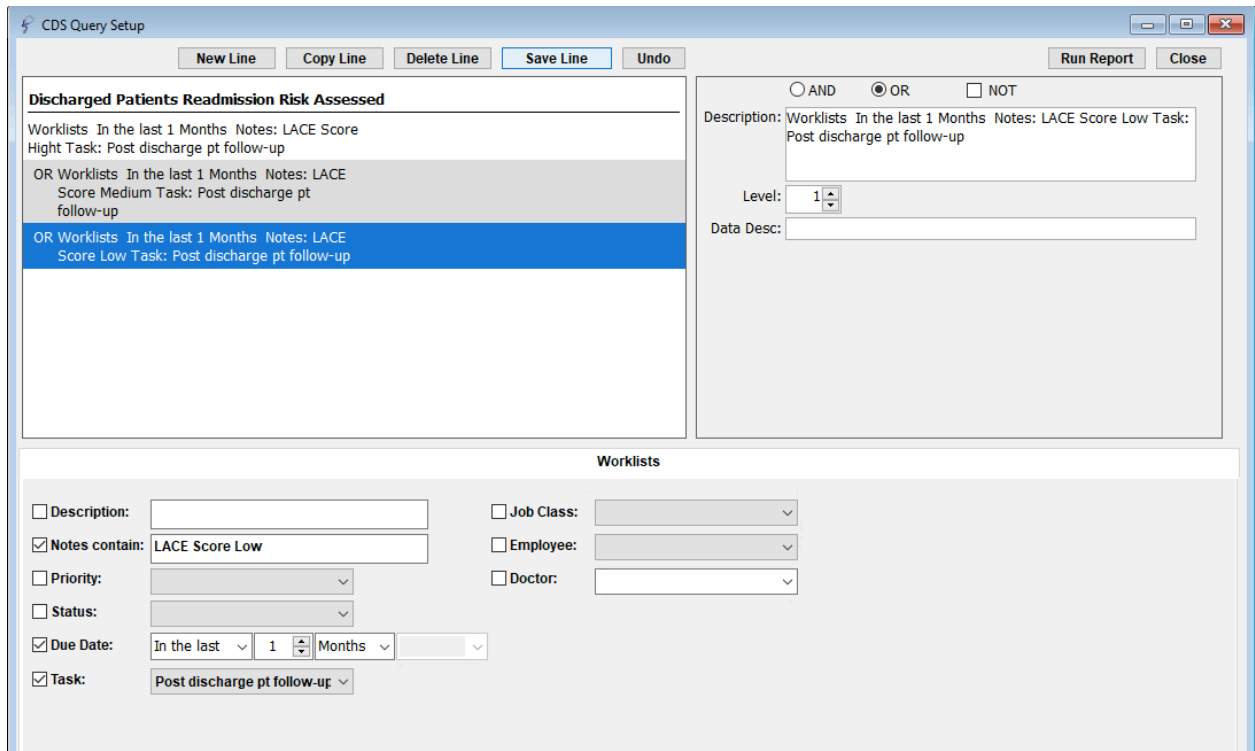
Other options are recording the risk score in the task description instead of the notes.

Denominator

The denominator is simply the **number of discharged patients in the same time period**. This query is looking to identify the patients from the received lab result (e.g., CII eNotification, AHS Summative Note of Discharge Summary, or Scan):
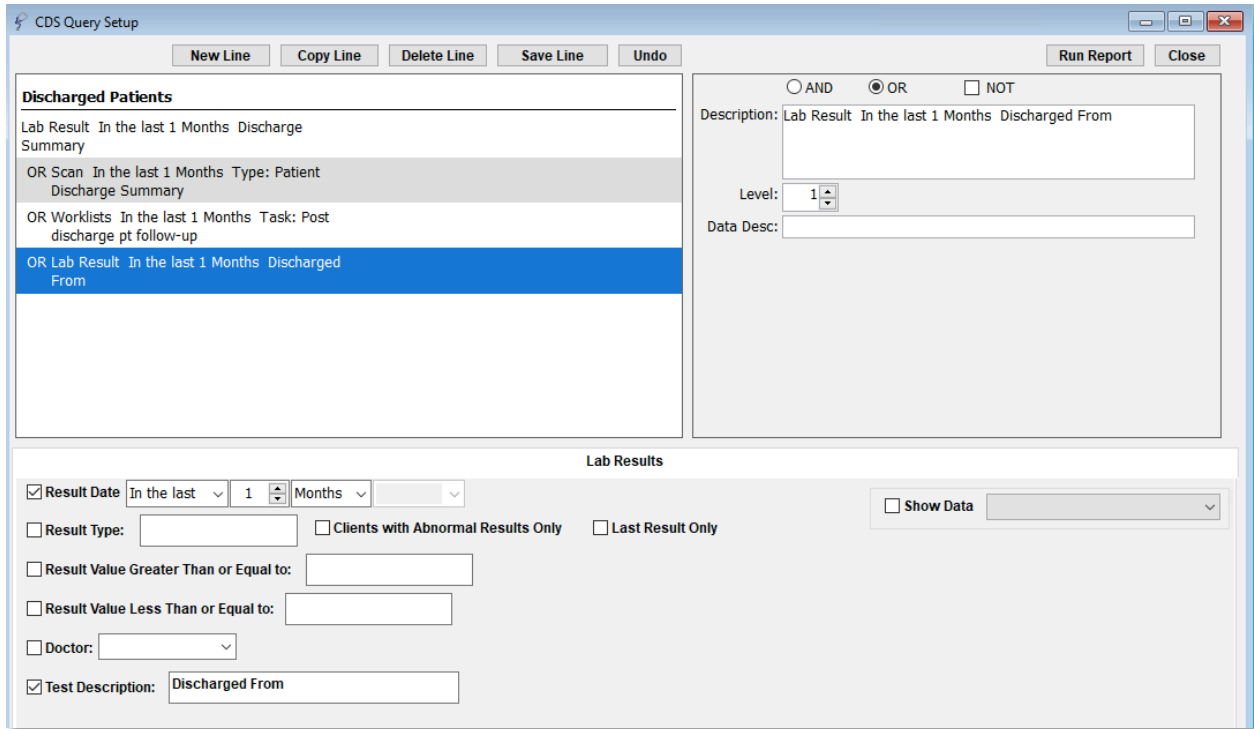
Potentially Better Practice 6.1: Develop a process to communicate with care providers outside of the medical home to facilitate transitions of care

The EMR activities for this section are aligned with the recommendations for Potentially Better Practice 2.1. Please see that section for details.

Outcome Measures

The purpose of H2H2H Transition is to assist primary care clinics in optimizing processes for paneled patients for effective transitions in care from home to hospital to home. H2H2H Transition outcome measure is to measure the impact changes have on % (#) of high risk of readmission patients with a visit within 14 days post hospital discharge. Gathering this data can identify patterns and trends for high risk of readmission patients that come into the clinic and assist the clinic to identify areas for improvement.

Start by determining your baseline to understand your current state. Determine an appropriate measurement interval (e.g., daily, weekly, monthly) and plot results to calculate a percentage: count ÷ total count.

Example measurement type: Methodology using ratio calculation

$$\frac{\text{the \# of patients that were scored as high-risk for readmission that had a clinic visit within 14 days of hospital discharge}}{\text{the total \# of patients that were scored as high-risk of readmission upon hospital discharge}} \times 100 = \text{\% of high-risk patients with a visit within 14 days post hospital discharge}$$

Saving this data to compare it with the next month for data analysis can assist the clinic to improve on certain activities. Leverage measurement skills from your practice facilitator, if possible.

To do this in Healthquest, there are various approaches you can take. One approach is to develop a query to identify all the patients that were discharged and determined to be high risk for readmission and another to query their visits to the clinic. Do this query per provider's panel.

What makes this challenging is that the results will have to be visually scanned and sorted to determine if the appointment was within 14 days of discharge.

Because the appointment is to within 14 days of discharge, it would be recommended to run a query 15 days into the next month to evaluate the previous month. For example, to determine the results for January run the query mid-February. Because Healthquest can query **in the last X months**, use 2 months as your time frame and only looks at those patients who were discharged in a given month.

Example query to identify patients at high risk of readmission with a visit post hospital discharge in the period being evaluated:

To identify the patients that were identified as high risk in the worklist task for post discharge follow-up and had an appointment for post-discharge follow-up, the query could look like this.

Important:
- By adding **Show Data** to lines of the query the appointment date, the appointment date will appear in the query results.
- Manually scan or export to a spreadsheet for analysis to compare the discharge date to the appointment date.
- When the results display, they can be sorted by Default Doc.
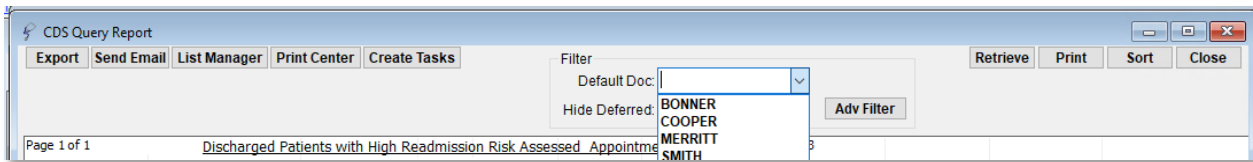
Note: It will be important to set the date ranges for these searches in the past to not include discharges where the patient hasn't yet had the opportunity to come in for follow-up. Using the example above of a 14-day period, the start of the date range should be at least 28 days in the past so that the end date is 14 or more days in the past.

Tips on process maintenance

Manually auditing some of your Search results to ensure they are producing accurate results is also a good time to review how well your clinic staff and physicians are following the discharge processes you've all agreed on. For example, you may find that your 14-day follow-up percentages are lower than expected according to your Search results, but then discover that not all clinicians are recording risk of readmission assessment correctly, so now your Search is inaccurate. Check in with any users that aren't following the process and get feedback on why not everyone is following the agreed upon steps. They may just need a refresher, they may be new staff and this process was overlooked during their training, or the process itself might not flow well with their workflow. In the latter case, consider asking some of those users to help co-design an updated process that will flow better, while still allowing you to have searchable results.

Balancing Measure

A balancing measure determines the impact of a change on a separate part of the system **and whether unintended consequences from changes to improve one part of the system have caused new problems elsewhere in the system.**

Did the changes made to improve clinic follow-up appointments for patients within 14 days post-hospital discharge have unintended consequences elsewhere in the system?

Using your EMR scheduler, determine Third Next Available Appointment (TNA) for each provider by counting the TNA weekly. It will be important to know if new processes designed to improve follow up care for transitioning patients has a negative effect on provider's overall TNA.

Measuring TNA in most EMRs can be a challenge. While a search for TNA is conceptually possible, in practice creating accurate searches for available appointments is difficult. Custom schedule templates and appointment types can make TNA searches unreliable. Since it is quick and easy to manually scan a provider's schedule for the third next free appointment, we recommend doing this process manually.

Notes for determining TNA:
TNA should be collected on the same day of the week (month) and at approximately the same time. Carve-outs are appointments held for specific kinds of patients or clinical needs. These time slots should not be included when counting TNA as they are in essence being held for special circumstances and can only be filled for and by the identified specific need.

Determine the length of your shortest appointment slot offered (e.g., 10 minutes). Longer appointments are comprised of multiples of these building blocks.

When counting the TNA weekly, look to see when the third next available empty building block is. Remember patient perspective of the wait is critical and so we must count the weekend.)
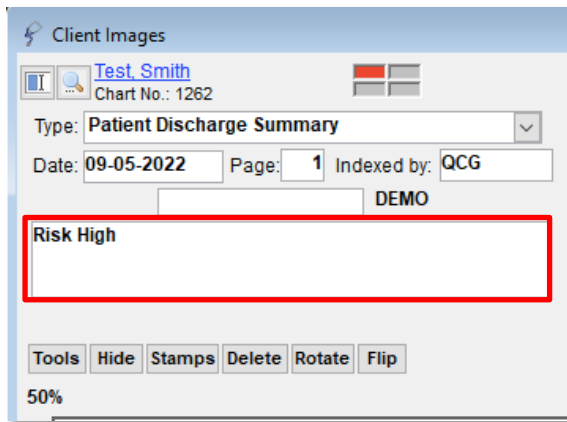
Optional

Tip: Highlight high risk patients in the received lab report or indexed scan/document to enhance visibility in the chart.

Received lab result with High Risk added as a note to the received result:

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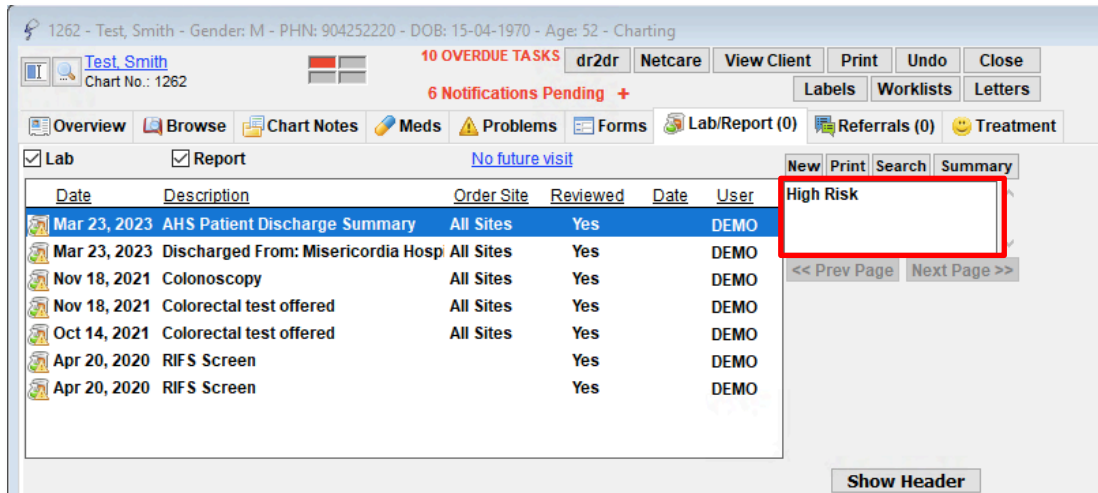
Indexed and scanned document with high risk added as a note:

This will display in the patient's overview area: