ALBERTA MEDICAL ASSOCIATION | ACTT Accelerating Change Transformation Team

PS Suite EMR Guide for Home to Hospital to Home Transitions

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EMR Advice to Potentially Better Practices

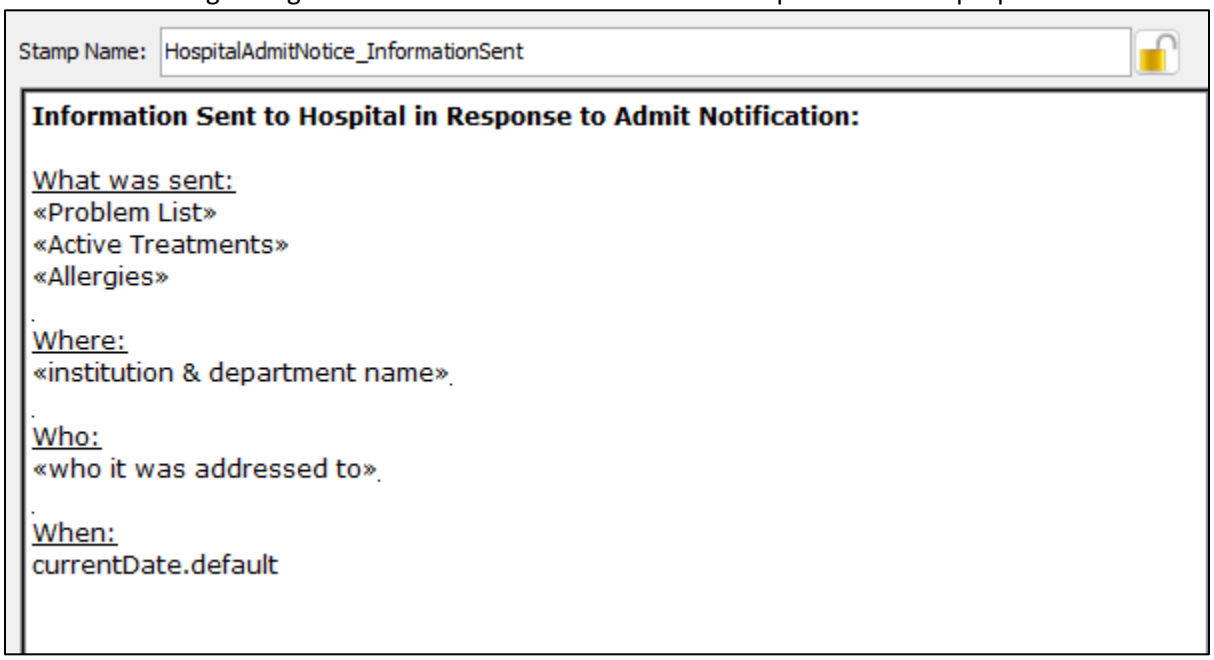
The following are organized by Potentially Better Practices (PBP) and their Process Measures outlined in the H2H2H Transitions Change Package Summary where EMR may be of assistance. For more rationale on the PBP refer to the *Rationale and Evidence*. For an additional list of measures and examples, refer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

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, while using 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.

There are several ways to do this PS Suite, but one common way is to stamp to record the information that was shared. You may want the body of this stamp to start with a unique title so that you can find all of these recordings using a PS Suite Search later. Here is an example of the stamp's potential content:



You may want to pre-populate **<<options>>** to select from under the **what info was sent** section, based on what your team has decided is appropriate to disclose to the admitting hospital. Please note that this screenshot is not a suggestion of what content you should be sending, this is only an example.

If your clinic plans to send this information to the hospital using PS Suite's letter function (via fax or e-fax), then you may have the content you want to send pre-populate into the stamp, so that you can use this stamp in a letter. To do this, replace the text in the **What was sent** section with keywords that will populate what content you want to send (e.g., enter **patPROB** instead of **<<Problem List>>** to have the contents of the problem list pulled directly into the stamp/letter).

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 information about key health care. 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.

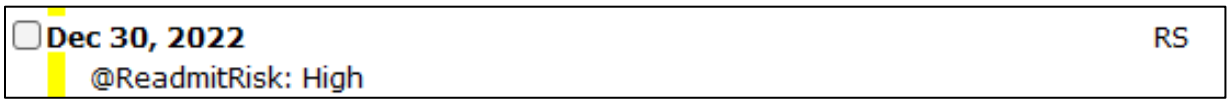
The EMR activities for this process are very similar to those for **Potentially Better Practice 4.1**. Please see Standardize entry of admit notifications, discharge notifications, and discharge *summaries* in the **Potentially Better Practice 4.1** section below.

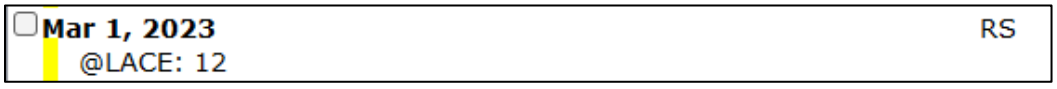
Potentially Better Practice 3.3: If a risk of readmission score has not been provided by acute care, develop a process to determine who your high-risk patients are

Not all hospital discharge notifications or reports will include information about the patient's risk of readmission. Each organization or clinic should have a process in place for determining and consistently recording each discharged patient's risk of readmission. This may be simply having the physicians review the list of discharged patients each day and have them assign a basic **high**, **medium**, **low** risk assessment, or it may involve something more complex like calculating a **LACE Readmission Index** score.

Whatever solution you choose, it should be searchable so that a list of high-risk patients can be generated. One way to do this in PS Suite is to create a custom vital, which is searchable and will allow your clinic to export the readmission risk results.

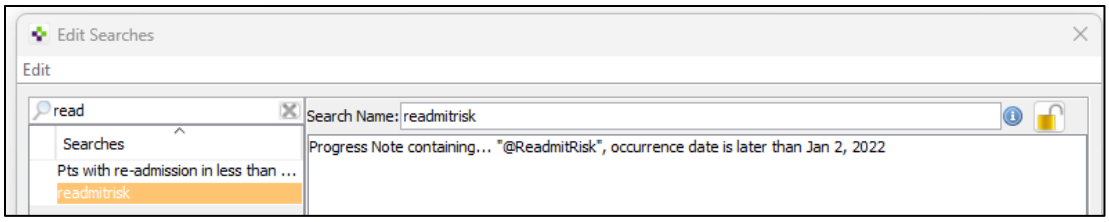
Two examples of custom vitals (in a progress note):



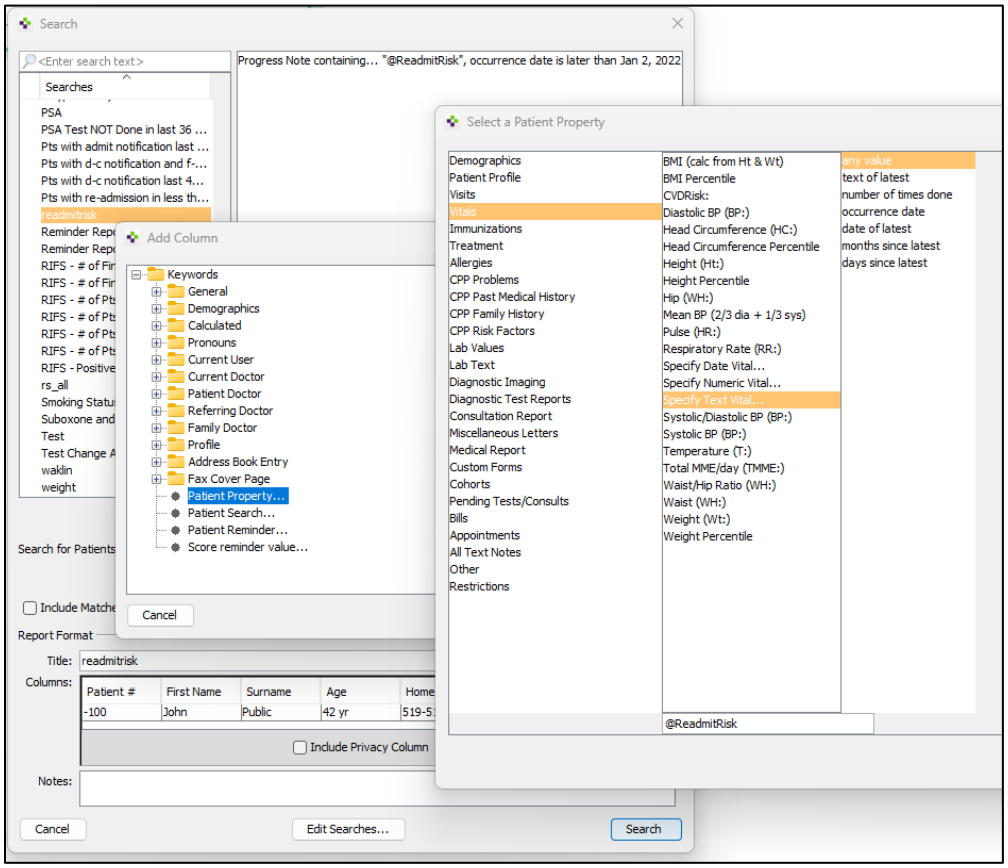


Example of a search to find and list the readmission risk results are below. A similar search could be built using the **@LACE** custom vital to find patients with a LACE score.

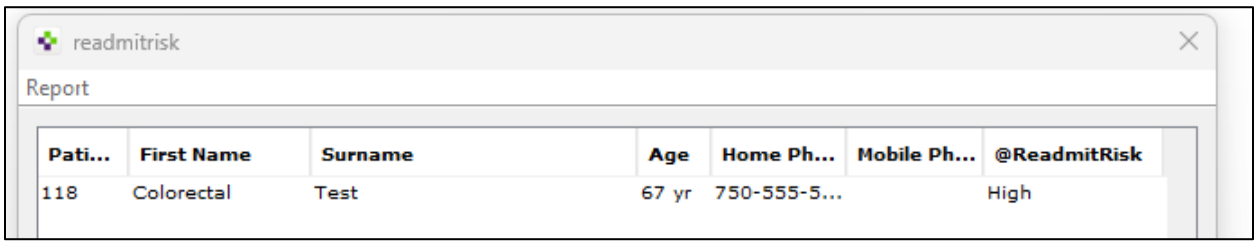
Creating the search:



Editing the search output to show the readmission risk:



Results of the search:



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

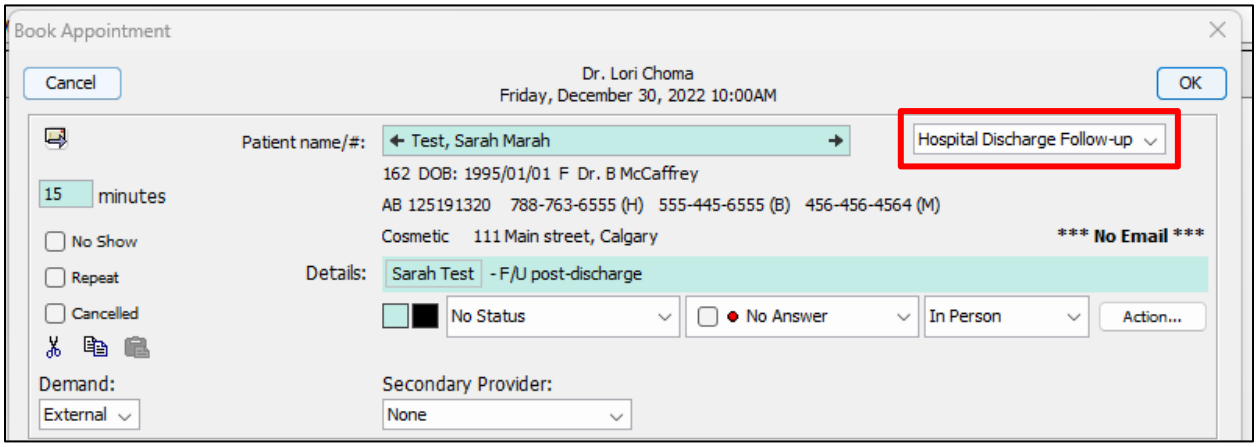
It is recommended that you record whether or not a follow-up visit was deemed necessary, and if so, whether it was booked or not.

It is recommended that the clinic come up with a list of standardized appointment reasons and create appointment types in the EMR. See the below table for suggested appointment types to use for different types of discharge notifications.

Suggested Discharge Notification Appointment Reasons for the "Details" Field:

Type of eNotification	Suggested Appointment Reason ("Details" field)
1. Emergency Room Discharge	ER D/C F/U
2. Hospital Discharge	Hospital D/C F/U
3. Day Surgery Discharge	Day Surgery D/C F/U

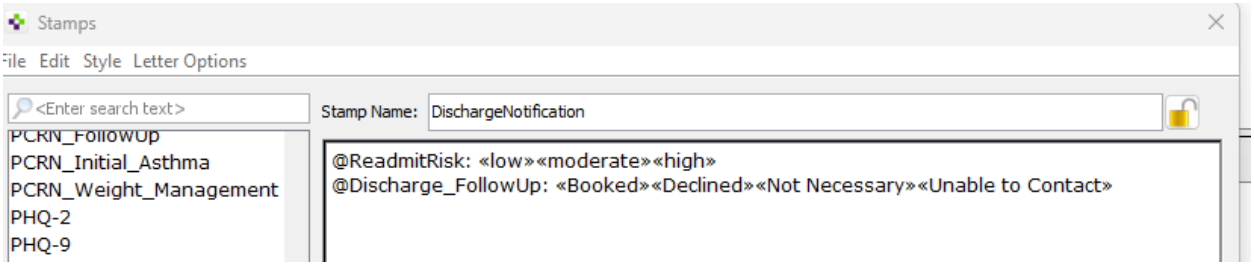
Alternately, you could decide as a clinic to simply use one **Appointment Type** for all discharge follow-up appointments.



At the time this follow-up appointment is offered, the attempt to book a follow-up appointment – and the outcome – should be recorded. This documentation should indicate whether the patient **accepted** the offer of follow-up, **declined**, if they were **unreachable** or it was determined that **no follow up is required.**

In PS Suite, this could be consistently recorded in the patient's chart; either as a separate stamp or incorporated into either of the previous stamps or letters described in 2.1 or 3.3 (above). For example, you could include a simple line in the stamp you used above to record the risk reduction score (or rating)

to also record the outcome of the follow-up appointment offer; this type of stamp should include a custom vital that will allow the clinic to search and export discharge data later:



Alternately, some clinics may decide to use a **PSS Message** to alert the physician of a hospital discharge, asking the physician to indicate whether a follow-up appointment is necessary. If this is the case, your clinic should agree to use the **Archive Message** checkbox that allows you to post a copy of the message to the patient's chart, to ensure that the follow-up decision/results are recorded. The initial message would ideally be compromised of a stamp that includes a unique text string to make it searchable (e.g. make the subject of the message **Discharge_Notificiation_Follow-up_Decision**).

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 health care events for their CPAR-paneled patients, including emergency room discharges, hospital admissions or discharges, and day surgery discharges. eNotifications are generally received in the EMR daily at 6 a.m., 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:
   - Specialty Consult Findings and Recommendations
   - Patient Discharge Summary
   - Emergency Department Provider's Notes
   - Post-Operative Notes

- Labour and Delivery Notes
- 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 PS Suite to Manage Incoming Admission and Discharge Notifications

Recommended method: eNotifications, Connect Care Summative Notes, and faxed hospital admission and discharge notifications should be categorized in PS Suite as **Reports**, using a standardized main category, and standardized sub-categories. This will ensure that the clinic can easily identify patients with a notification received within the last 48 hours and complete any necessary follow-up steps.

Hospital admission and discharge notifications can be accessed from the **Lab Reports Inbox** window (Records à File à Lab Report Inbox). In this window, each notification can be opened separately. When viewing an individual hospital admission or discharge notification report, ensure that a main category and at least one sub-category have been assigned from the **PS Categories** list. Note that eNotifications may have already had a main category and sub-category automatically assigned to them. In this case, clinics may choose to assign additional sub-categories as appropriate. Below is a table of suggested main

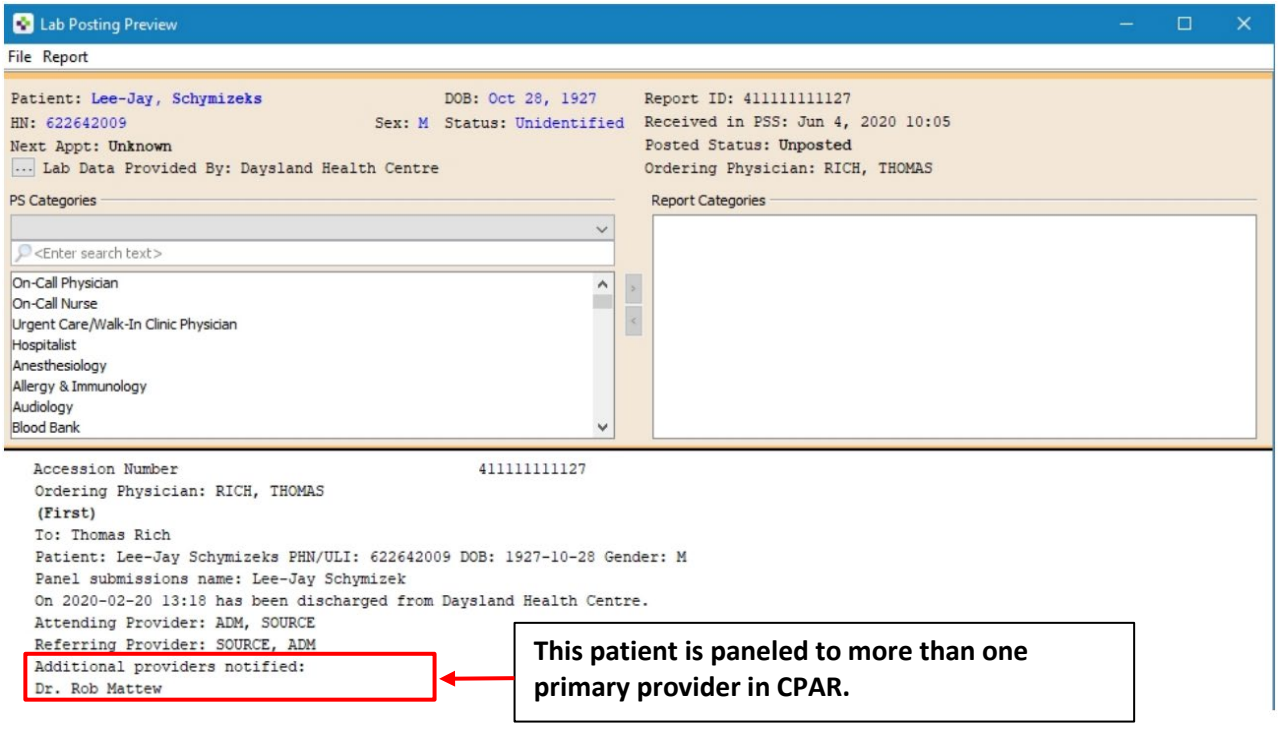
and sub-categories for each type of eNotification received. Note that the same categorization principles apply to notifications received by fax.

Suggested EMR Categories for eNotifications:

Type of eNotification	Suggested Main Category	Suggested Sub-Category*
1. Emergency Room Discharge	Medical Reports	Emergency Room Discharge eNotification
2. Hospital Admission	Medical Reports	Inpatient Admission eNotification
3. Hospital Discharge	Medical Reports	Inpatient Discharge eNotification
4. Day Surgery Discharge	Medical Reports	Day Surgery Discharge eNotification [Discharge Summary]

After Categorization: after reviewing the notification details, the user needs to decide if any action is necessary (e.g., does the patient need to be contacted to offer a follow-up appointment with primary care?). Does the hospital need to be sent important information about an admitted patient? This should be a decision-making process that is well-established at your clinic, and that everyone involved should be aware of and practice. At the very least, a readmission risk rating/score should be entered into the patient record in whatever method your clinic has agreed to use (see Potentially Better Practice 3.3 for examples). After the report is categorized and filed to the patient's chart, whoever filed it should record what the decision was regarding next steps. See **Potentially Better Practice 3.4** for examples of how to record next steps consistently and accurately.

Multiple CPAR Providers: For providers on CII/CPAR, if another provider is listed on the eNotification



(see below screen shot for an example), this indicates that the patient is paneled to more than one provider in CPAR.

This is an opportunity to confirm which provider the patient considers their primary provider. Your last CPAR Conflict Report will inform you when the patient was last seen and confirmed by the other provider. When contacting the patient for follow-up you can indicate that another provider also received the notification. If the patient considers the other provider to be their primary provider be sure to change their demographics appropriately. For additional information on resolving panel conflicts identified through CII/CPAR, please see the CPAR Panel Resources webpage for helpful resources.

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

Patient Risk Assessment

Before a patient is discharged from hospital, it is recommended that the acute care team complete a patient risk assessment to identify the patient's risk of re-admission. The completed risk 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 below.

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 has a Process Measure that allows a clinic to track how well their risk assessment documentation process is working, and to determine whether the process needs improvement.

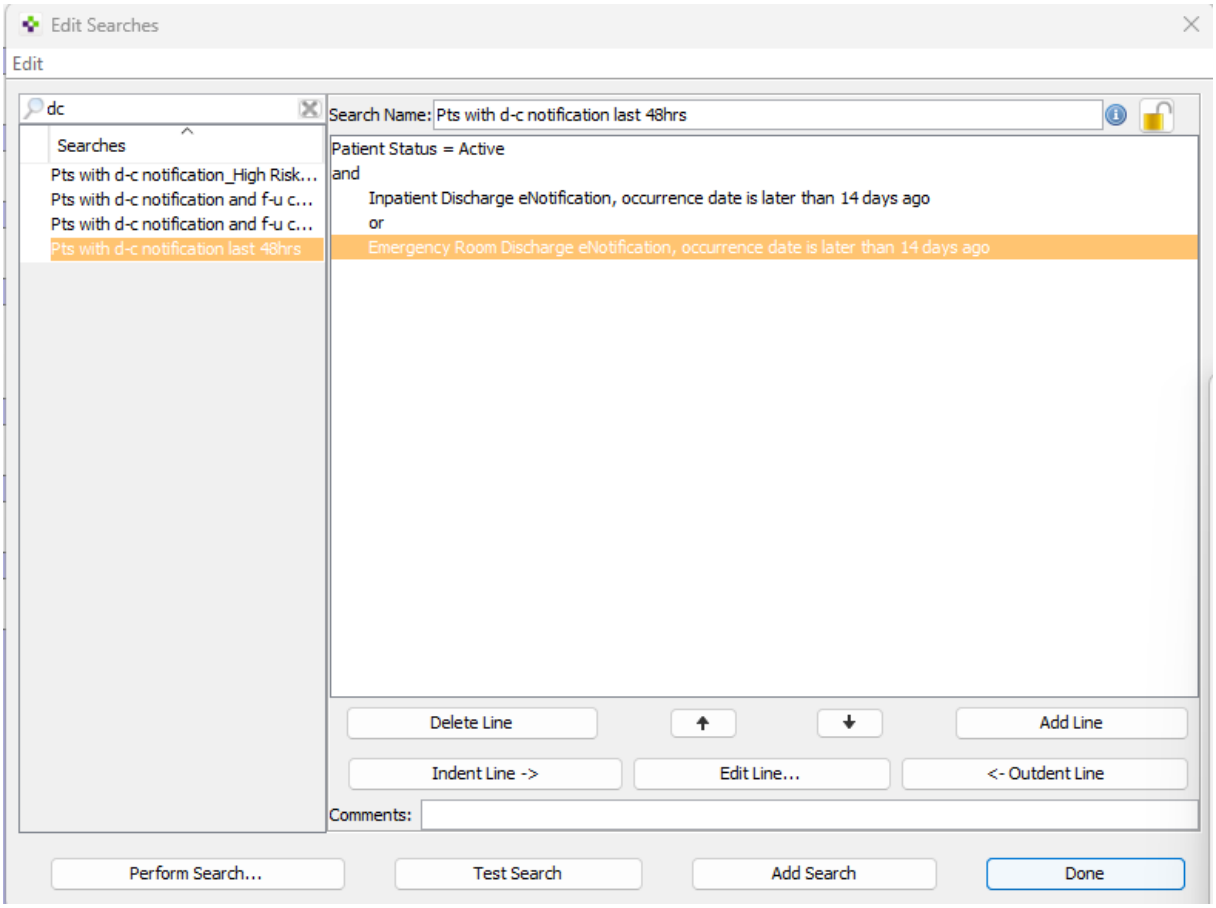
Start by determining your baseline – this is the first measurement you take once the measurement process is in place. Then, determine an appropriate measurement interval (e.g., daily, weekly, monthly) and plot results to calculate a percentage: count ÷ total count.

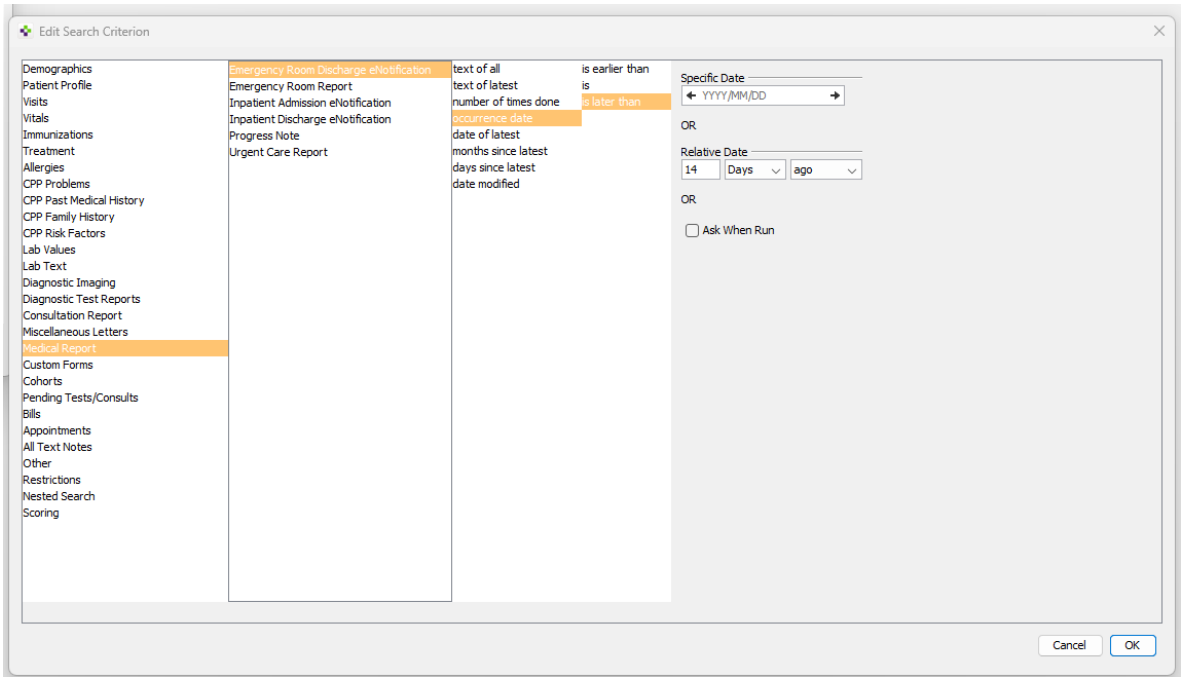
The key process measure here is the percentage of patients for whom your clinic received a discharge notification and also had a risk assessment (e.g. a LACE score, or other readmission risk type that your clinic uses) documented in their electronic chart. This is calculated as follows:

Example measurement type: Methodology using ratio calculation		
$\frac{\text{the \# of patients with risk of readmission assessment documented in the patient record}}{\text{the total \# of discharged patients}}$	$\times 100 =$	% 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 assessments in the patient record. Leverage measurement skills from your practice facilitator, if possible.

Please see **Potentially Better Practice 3.3** (above) for examples of how to record readmission risk scores in PS Suite in a way that allows them to be identified via a **PS Suite Search**. Following this process or a similar one, and then running a search like the one outlined in 3.3, will allow you to get the numerator (total # patients with a risk assessment) for the above calculation. A separate **Search** will need to be created to determine the denominator (total # of discharged patients). An example of such a search is in the screenshot below. Also below is another screenshot that indicates where to find the search criteria for all types of eNotifications. Please ensure that your discharge notifications, from all sources, are captured by the search criteria. You may also want to modify the **occurrence date is later than…** search criteria to reflect your chosen measurement interval.





Potentially Better Practice 6.1: Communicate as needed post-transition with care providers outside of the medical home

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 is to assist primary care clinics in optimizing processes for paneled patients for effective transitions in care from home to hospital to home. One of the key outcome measures for H2H2H is the percentage of high-risk patients that had a follow-up encounter with your clinical team within 14 days post hospital discharge. If this percentage is low, this may lead to higher readmission rates, and potentially to worse health outcomes.

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:

Example measurement type: Methodology using ratio calculation

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

Tracking this data at routine intervals (e.g., monthly) can track your progress after implementing some of the Potentially Better Practices outlined in this guide. If this measure is initially low, have your team discuss a realistic goal (with a timeframe, and target %), and review your processes that may be impacting your team's ability to check-in with high-risk patients after discharge.

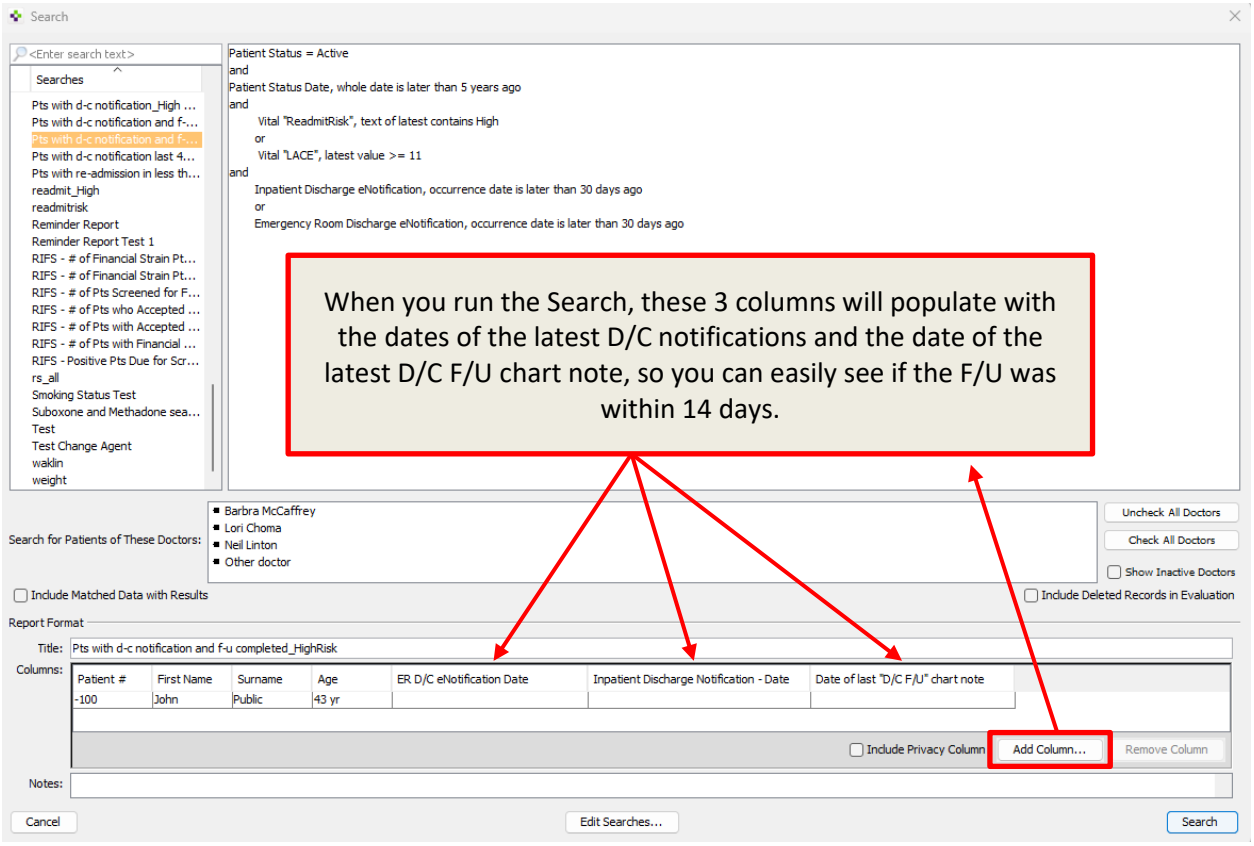
Please review your clinic's method of recording post-discharge encounters and ensure the language of the search criteria captures those encounters. For the search examples provided below to work, the clinic would need to consistently chart post-discharge encounters with text that includes **D/C F/U**. A stamp that all clinicians are trained to use for post-discharge encounters is very helpful for creating consistent, searchable encounters.

Note: In PS Suite, it can be difficult to run searches that measure the intervals (times and dates) between events, especially if you are trying to run these searches retroactively. For example, it is difficult to design a process in PS Suite to specifically measure whether a high-risk patient was seen within 14 days of discharge.

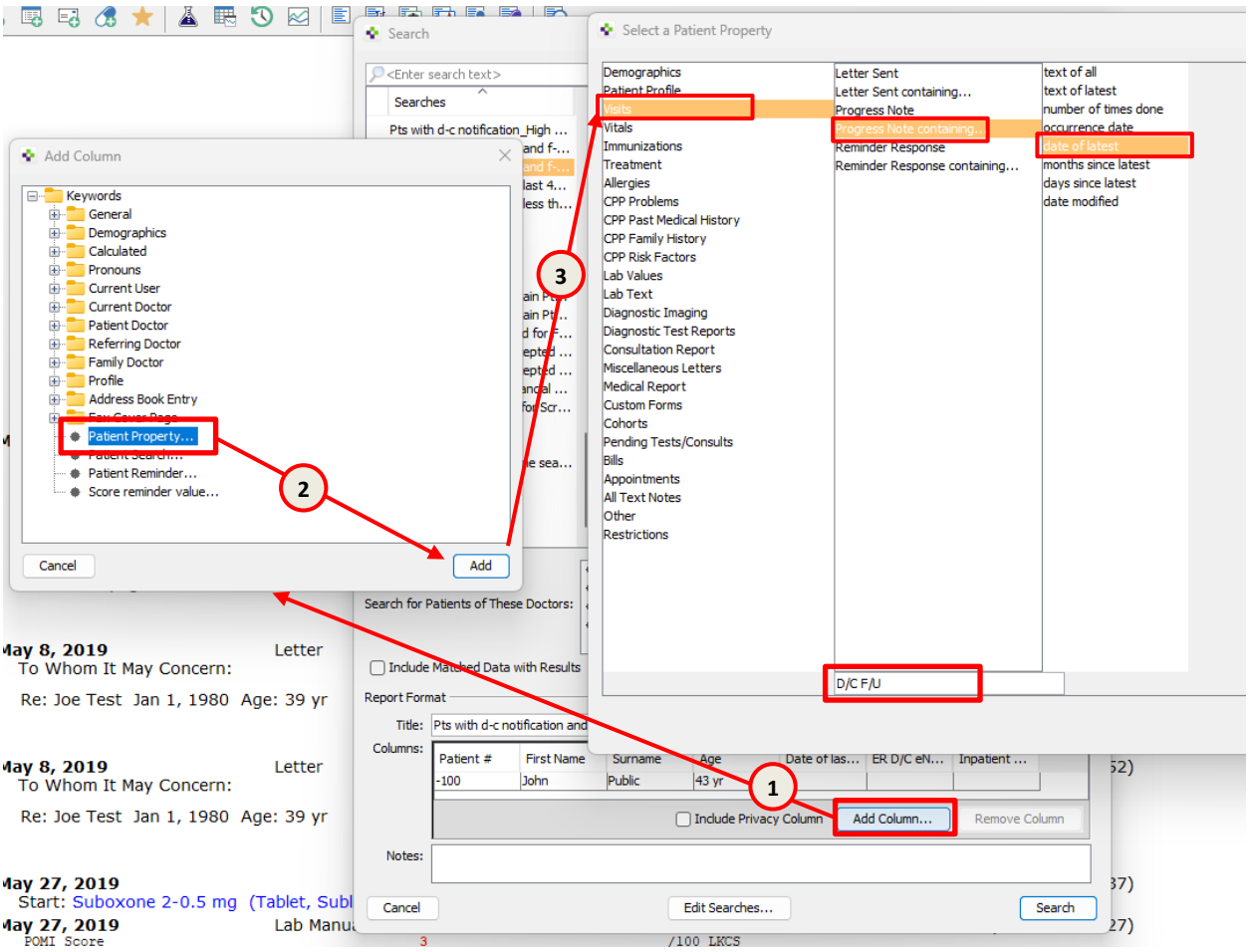
To get around this limitation of the search criteria, you may use a search like the one below, which identifies patients that have received a discharge notification within the last 30 days, and have had a custom vital of **@ReadmitRisk: high** or **@LACE:** of 11 or higher (which is consider high risk for readmission). However, this search alone won't tell you if they had a follow-up or not, or whether that follow-up was within 14 days. You can however add this data as columns to include in the search results table. The resulting search will find all relevant patients (your denominator), and then you can manually

look through the table to see if the dates for follow-up appointment are within 14 days of the discharge notifications.

See the screenshot below for an example of an edited search results table, which has added columns for the dates of the latest discharge notifications and the date of the latest chart note with the **D/C F/U** stamp in it. When you run the search, any patients with a blank in the D/C F/U column did not have a **D/C F/U** stamp in it and may not have had a discharge follow-up appointment at all (assuming clinicians are using the stamp).



Below is a screenshot of how you might add the column that pulls the date from the last chart note with the **D/C F/U** stamp/text in it:



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 of your clinicians are recording the follow-up encounter using the proper stamp (or whatever method was chosen), so now your search is overlooking those encounters. Check in with any users that aren't following the process and get feedback on why not everyone is following the proper steps. They may need a refresher, 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, 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 PS Suite can be a challenge. While there is a pre-built TNA Report in PS Suite (found via **Appointments > View > Office Efficiency > Reports** window), it may not always produce reliable results. Custom schedule templates, blocks placed provider's schedules to indicate specific appointment types, and other common practices with PS Suite schedules make automated TNA reports unreliable. Since it is quick and easy to manually scan a provider's schedule for the third next free appointment, we generally 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.)