ALBERTA MEDICAL ASSOCIATION | ACTT Accelerating Change Transformation Team

# Measurement Guide

**Home to Hospital to Home Transitions Change Package**

## Contents



## Introduction

The following measures have been developed to support primary care clinics in implementing practice improvements for patients transitioning from home to hospital and back home again. Clinics are the primary and sole users of their quality improvement data collected. Therefore, clinics should determine the data that provides the most value and are most relevant to their process improvement. Clinics are not being asked to submit data to any organization. The list of measures is not exhaustive, and you are free to develop other measures not included.

# Alignment with Transitions Measures and CII/CPAR

Many of these sample measures can be captured in the EMR. In many cases, you may identify a need for some process improvement in use of the EMR or data entry standardization to allow the EMR to be optimized to report these measures. See EMR Guides for recommended EMR activities about how to utilize EMR in primary care settings to optimize processes for paneled patients transitioning from home to hospital and home. Taking the time to establish these EMR practices will build transferable skills and capacity. For additional information about the technical enabler, can be found here at CII/CPAR.

# Timing and Methodology

The frequency and timing of measurement for quality improvement is at the discretion of the clinic, and dependent on the behaviour change and measure being tracked. It is recommended that measures are collected as frequently as possible without adding burden. For example, weekly measurement of discharges or admissions may be appropriate. Data can be entered into a simple Excel spreadsheet and run charts may be created to support interpretation. See Tools & Resources for Implementing Change for more details on run charts.

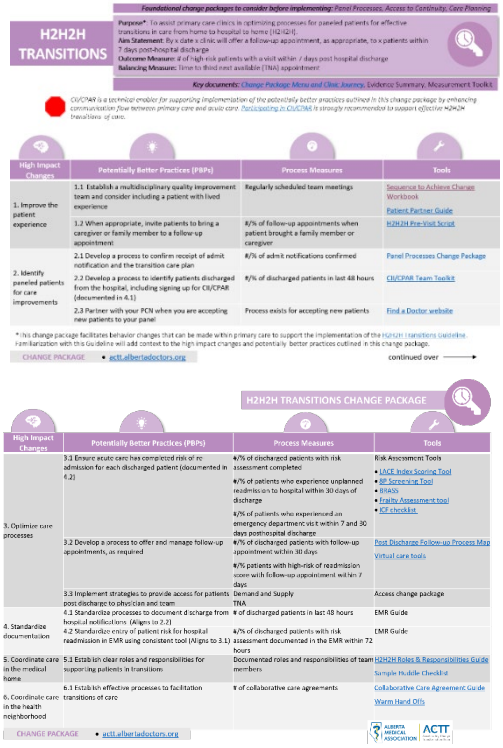


*Figure 1. H2H2H Transitions Change Package Summary*

# Measures Summary for the H2H2H Transitions Change Package

Measures indicated below are further described in the H2H2H Change Package Summary.

## Outcome Measures

An outcome measure measures the performance of the system under study. It often relates directly to the aim of the project and offers evidence that changes are having an impact. In this case:

*The impact of the change being implemented to optimize the % (#) of high-risk patients with a visit within 14 days post-hospital discharge*

## Outcome Measurement Example

To calculate a percentage: count ÷ total count. This can help you identify patterns and trends.

**Example measurement type: Methodology using ratio calculation**

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

## Process Measures

Each potentially better practice has a list of proposed process measures that measures whether an activity has been accomplished. Process Measures are often used to determine if a PDSA cycle was carried out as planned. Included in this Measurement Guide are some instructions, examples, and additional information for each proposed measure. Most of these measures can be captured in the EMR or creating a checklist or tracking #/%.

**Table 1.** Potentially better practices and sample process measures extracted from H2H2H Change Package Summary.

| Potentially Better Practice | Process Measure |
|---|---|
| 1.1 Establish a multidisciplinary quality improvement team and consider including a patient with lived experience | Regularly scheduled team meetings |
| 1.2 When appropriate, invite patients to bring a caregiver or family member to a follow-up appointment | Clinic has a pre-visit script and processes to apply it |

| | |
|---|---|
| 2.1 Upon receipt of admit notification, develop a process to provide hospital team with any relevant patient information | Process is documented for notifying hospital team of relevant patient information |
| 2.2 Develop a process to identify patients discharged from the hospital (using electronically received discharge notices) | Process exists for identifying patients discharged |
| 2.3 Partner with your PCN when you are accepting new patients to your panel | Process exists for accepting new patients |
| 3.1 Develop a process to review patient discharge summary* from hospital<br>*The H2H2H Transitions Guideline uses 'transition care plan' to describe the discharge summary' | Process is documented for reviewing discharge summary |
| 3.2 Develop a process to check each discharge summary for a risk of readmission score* (documented in 4.1) | Process is documented for checking 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 | A process is documented for determining high-risk patients |
| 3.4 Develop a process to offer and manage follow-up care, as appropriate | A process is documented for offering and managing follow up care |
| 3.5 Create a plan for the patient appointment (e.g., medication reconciliation, review care plan, results and outstanding test follow up) | A plan is documented |
| 4.1 Standardize entry of admit notifications, discharge notifications and discharge summaries<br>4.2 Standardize entry of patient risk for hospital readmission in patient record (Aligns to 3.2) | #/% of discharged patients with risk assessment documented in the patient record |
| 5.1 Establish clear roles and responsibilities for supporting patients in transitions | Documented roles and responsibilities of team members |
| 6.1 Communicate as needed post-transition with care providers outside of the medical home (e.g., primary care accessing specialist advice and liaising with homecare or other members of the extended healthcare team) | Process in place for contacting specialist advice programs, homecare and other |

## Process Measure Examples

The following are examples of how a clinic team may collect measurement data.

### *Example #1: Methodology using a checklist*

A checklist is a convenient way of ensuring you remember to follow every step systematically, every time. By using checklists, clinics can improve quality and cost by reducing the number of steps missed and preparing ahead.

| Example measurement type: Using a checklist | | |
|---|---|---|
| Checklist ☐ | Yes/no confirmation ☒ ☑ | Flow chart |

**This can be applied to the following Potentially Better Practices:**

1.1 Regularly scheduled team meetings
1.2 Clinic has a pre-visit script and processes to apply it
2.1 Process is documented for notifying hospital team of relevant patient information
2.2 Process exists for identifying patients discharged
2.3 Process exists for accepting new patients
3.1 Process is documented for reviewing discharge summary
3.2 Process is documented for checking risk of readmission score
3.3 A process is documented for determining high-risk patients
3.4 Develop documented for offering and managing follow up care
3.5 A plan is documented
5.1 Documented roles and responsibilities of team members
6.1 Process in place for contacting specialist advice programs, homecare and other

*Example #2: Methodology using ratio calculation*

To calculate a percentage, it can be calculated as: count ÷ total count. This can help you identify patterns and trends. 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.

| 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 |

## 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**.** In this case, 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.

Time to Third Next Available Appointment (TNA) is evidenced in international literature and can be used to help measure and determine the potential risk of change. It is supported by the Institute of Healthcare Improvement (IHI) for access improvement work. Knowing the delay for your patients to get

in to see you is the critical first step to improving access. Delay for appointments has a negative impact on continuity of care between physician and patient.

### Balancing Measure Example: How to Measure Third Next Available Appointments (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, so we must count the weekend.

| **Tools:** |
| --- |
| TNA Toolkit - Toolkit for Time to Third Next Available Appointment Indicator<br>Run Charts - Record the value in a tool to create showing data over time and analyze. |

# Resources

## EMR Guides

EMR Guides are being created for the current top six EMRs used in Alberta (e.g., Microquest-Healthquest; Telus-Med Access; Telus-PS Suite; Telus-Wolf; QHR-Accuro, Ava). These guides will offer specific guidance, step-by-step instruction, recommendations, and screen shots of each EMR to support both measurement and quality improvement for the H2H2H Transitions Change Package. These will be available on the ACTT website.

## Other Data Sources

HQCA Primary Health Care Panel Reports are available, by request, for free for any primary care physician. These panel reports include practice and panel characteristics, information on chronic conditions, pharmaceuticals, and health care utilization that can be used in quality improvement.

The HQCA FOCUS data provides additional data that can be examined by Zone or PCN.

Zone working groups may have access to additional data relevant to your Zone or PCN.