

Med Access EMR Guide for Home to Hospital to Home Transitions

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Contents

EMR Advice to Potentially Better Practices	3
Potentially Better Practice 2.1: Upon receipt of admit notification, develop a process to provide hospital team with any relevant patient information.....	3
Process Measure 2.2: Process exists for identifying patients discharged.....	4
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	4
Potentially Better Practice 3.4: Develop a process to offer and manage follow-up care, as appropriate .	5
Potentially Better Practice 4.1: Standardize entry of admit notifications, discharge notifications, and discharge summaries.....	7
Potentially Better Practice 4.2: Standardize entry of patient risk for hospital readmission in patient record.....	8
Potentially Better Practice 6.1: Communicate as needed post-transition with care providers outside of the medical home	10
Outcome Measures	11
Balancing Measure.....	14

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](#).

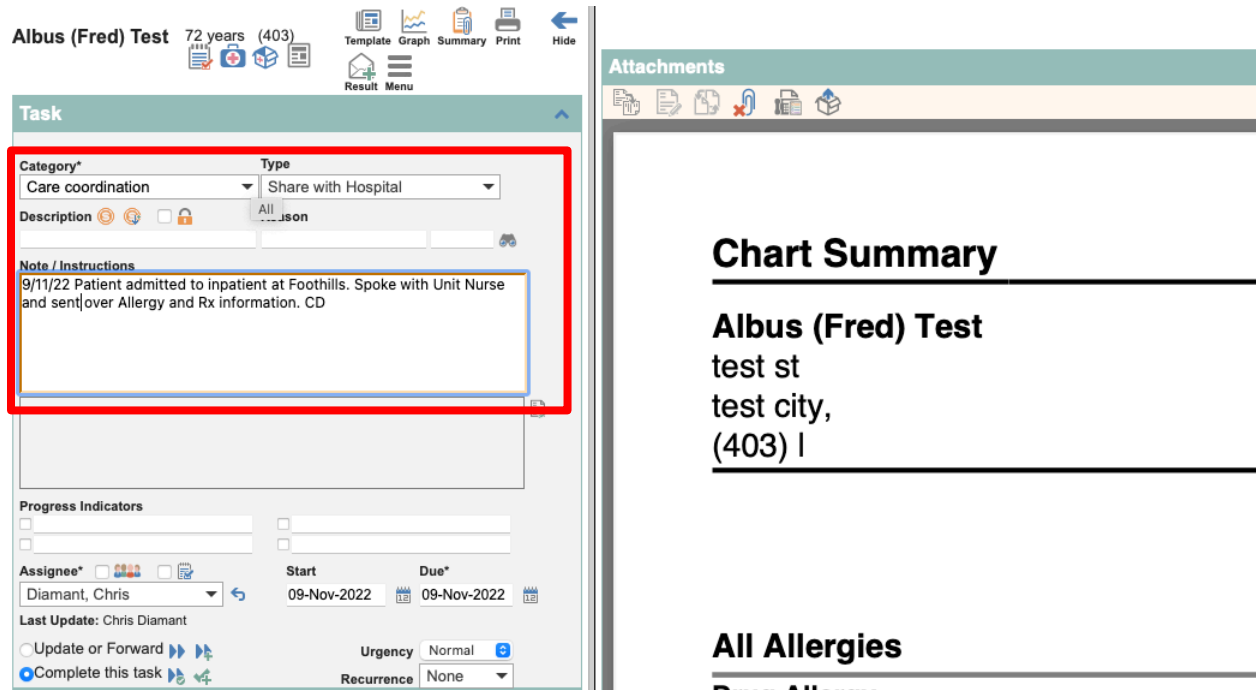
Standardized Text

Wherever possible teams should use standardized text. This may include multi select observations like dropdown lists or, macros which specify standardized text that can be dropped into free text fields. For more information about how to use observations or macros in Med Access see the online help files.

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.

A common way to do this in Med Access is to record the exchange of information in a **Care Coordination** task. Entering consistent information in the **Type** and/or **Description** fields will allow the team to filter and search for these specific kinds of **Care Coordination** tasks.



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.

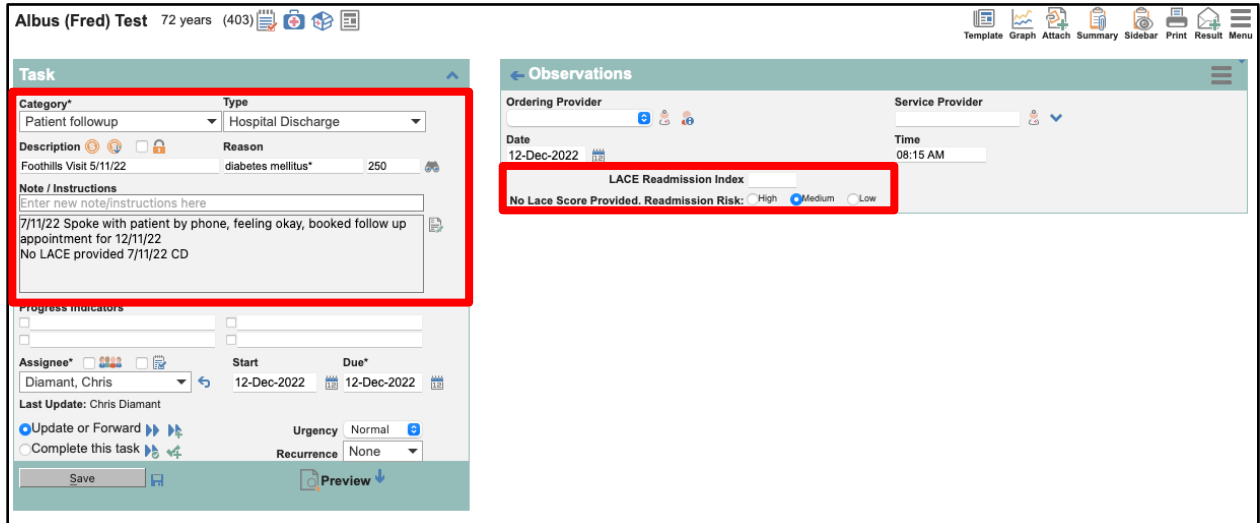
The EMR activities for this process are very similar to those for **Potentially Better Practice 4.1**. Please see Using Med Access to Manage Incoming Admission & Discharge Notifications in the **Potentially Better Practice 4.1** section below.

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 patients are

Document all patient communication in the chart – who, when, outcome. This can be done in a **Patient follow-up** task. Be sure to enter consistent information in the **Type** and **Description** fields so these tasks can be filtered for and searched easily.

Creating a **Task** template can make data entry more efficient and include a specific field to record the patient’s risk of readmission level. If a readmission risk score has not been provided, your record could

be as simple as an observation with **Low, Medium** or **High** readmission risk options. Whatever solution you choose, it should be searchable so that a list of patients at high risk for readmission can be generated:

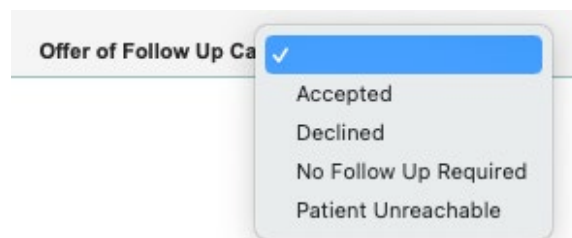


TIP: For more information on how to create Task templates in Med-Access please refer to the Med Access Online Help section: *Admin > Templates > Task Templates > Creating general task templates from the Template Management area*

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 booked. A simple observation could be created to record if the patient **accepted** the offer of follow up, **declined**, **was unreachable** or had **no follow up required**. This observation could be added to the **eNotification** or **Summative Notes** task that alerted the clinic to the event so the result could be recorded in the same task.



Using this simple dropdown consistently will make follow-up results searchable for future panel management and QI work.

Creating follow-up appointments

The clinic team contacts the patient to book an appointment and records the outcome in the EMR. 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 for the “Details” Field:

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

Example:

Registered Patient
Albus (Fred) Test
 72 years 13-Apr-1950 Male
 (403)
 Address: test st, test city
 Provider: T. MD
 Notes: Elderly, hard of hearing

Appointment
 Appointment provider is not the same as patient's primary provider.
 Last BMI > 12 months old
 Last BP > 6 months old
 No Complete within 365

Type: **Hospital D/C F/U**
 Concern: Heart Attack - Follow up after Foothills Hospital visit 5/11/22
 Date: 09-Nov-2022 Wednesday
 Time: 01:15 PM - 01:30 PM 15 minutes
 Status: Booked
 Provider: MD, Test
 Bill Provider: MD, Test
 Referring Provider: [Red X]
 Resource: [Red X]
 Facility: [Red X]
 Room: [Red X]
 Equipment: [Red X]
 Bill: [Red X]
 Visit: [Red X]
 Task: [Red X]

Save

01:15 Albus (Fred) Test 13-Apr-1950 (72) M Hospital D/C F/U Heart Attack - Follow up after Foothills Hospital visit 5/11/22 Booked Edit

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:
 - 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 Med Access to Manage Incoming Admission and Discharge Notifications

Recommended method: eNotifications, Connect Care Summative Notes and faxed hospital admission and discharge notifications should be recorded in Med Access in the same category of task. That way the clinic can easily identify patients with a notification received within the last 48 hours and complete any necessary follow-up steps. This will also make it easier to generate lists of admitted and discharged patients for panel management and quality improvement initiatives.

On initial setup, Med Access receives eNotifications as **Investigation** category tasks and Connect Care Summative Notes as **Consult** category tasks. Fortunately, Med Access allows users to configure the EMR to re-categorize these tasks automatically as they are created in the EMR. This offers Med Access users the freedom to choose what type of category they'd like to assign to these tasks and ensures they will be consistently categorized.

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 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 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 searches in Med Access:

Numerator

To find the numerator it will be necessary to find the number of discharged patients who had a risk of readmission score recorded in their discharge task. The search might look something like this:

The screenshot shows the 'Practice Mgmt Reporting' interface. On the left, the 'Criteria' section is expanded to show search filters:

- Template:** Discharged with Risk
- Demographics:** (collapsed)
- Profile:** (collapsed)
- Visits:** (collapsed)
- Task:**
 - Category: Patient followup
 - Type: Hospital Discharge
 - Task Date: Back 2 weeks Ahead None
- Observation:**
 - Category: All
 - Observation: LACE Index for Readmission (Exact)
 - or: No LACE Score Provided, Re (Exact)
 - Date: 28-Feb-2023 to 14-Mar-2023
- Medications:** (collapsed)
- Allergy:** (collapsed)

On the right, the 'Reports' section shows 'Type: Patient Count'.

Denominator

The denominator is simply the number of discharged patients in the same time period and should be easier to find:

The screenshot shows the 'Practice Mgmt Reporting' interface. On the left, the 'Criteria' section is expanded to show 'Task' details. The 'Task' section includes a 'Category' dropdown set to 'Patient followup', a 'Type' dropdown set to 'Hospital Discharge', and a 'Task Date' range from '2 weeks' back to 'None' ahead. Other criteria sections like 'Demographics', 'Profile', 'Visits', 'Observation', 'Medications', and 'Allergy' are collapsed. On the right, the 'Reports' section is visible, with a 'Type' dropdown set to 'Patient Count'. Below the reports section are 'Searching' and 'Services' sections, both collapsed.

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 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 med access you'll need to create some Practice Management Reports to find the numerator and denominator for the equation above.

Numerator

The numerator calculation is complex. It assumes that the EMR has reliable and searchable information for patient discharges, readmission risk scores and visits. It will also require some work outside of the EMR. Since Med Access cannot generate a report that will look at each discharge individually to see if a visit has taken place within 14 days, two reports will be needed. One to generate a list of patients with discharge tasks with high-risk of readmission observations, and one to generate a list of patients with high-risk of readmission observations and visits. Once you have these two lists you will need to compare the discharge task dates with the visit dates to see who was seen within 14 days and who was not.

The numerator searches might look something like this:

Patients with Discharge Tasks with high risk of readmission observations:

Practice Mgmt Reporting

Criteria	Reports
Template: Discharged with High Demographics Profile Visits Task Category: Patient followup Type: Hospital Discharge Task Date: 2 weeks Ahead None Observation Category: All Observation: () last Exact LACE Index for Readmission > (9 as Number) or () last Exact No LACE Score Provided. Re Contains (high as String) Date: 28-Feb-2023 to 14-Mar-2023 Medications Allergy	Type: Patients List Field Filter: Select Template... Searching Services

Patients with Visits and high risk of readmission observations:

Practice Mgmt Reporting

Criteria	Reports
Template: H2H2H Visits with Hig Demographics Profile Visits Date: 28-Feb-2023 to 14-Mar-2023 Signed? Task Observation Category: All Observation: () last Exact LACE Index for Readmission > (9 as Number) or () last Exact No LACE Score Provided. Re Contains (high as String) Date: 28-Feb-2023 to 14-Mar-2023 Medications Allergy Goals Billing Appointment	Type: Patients List Field Filter: Select Template... Searching Services

Once the two lists are generated, they'll need to be compared to match patients to see who had a high risk of readmission discharge followed up with a visit, and who did not.

Denominator

The search for the denominator is the same as the first search above: the number of patients with high risk of readmission who have had a discharge within a 14-day period.

Practice Mgmt Reporting

Criteria	Reports
<p>Template: H2H2H Discharged w</p> <p>Demographics</p> <p>Profile</p> <p>Visits</p> <p>Task</p> <p>Category: Patient followup Type: Hospital Discharge Task Date: 28-Feb-2023 to 14-Mar-2023</p> <p>Observation</p> <p>Category: All</p> <p>Observation: LACE Index for Readmission > 9 as Number or: No LACE Score Provided, Re Contains high as String</p> <p>Date: 28-Feb-2023 to 14-Mar-2023</p> <p>Medications</p> <p>Allergy</p> <p>Goals</p> <p>Billing</p> <p>Appointment</p>	<p>Type: Patient Count</p> <p>Searching</p> <p>Services</p>

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 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 of your 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 proper 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?

If your practice is already producing Third Next Available (TNA) run charts for each provider before making these changes, it will make observing any unintended consequences on TNA more apparent.

If not, 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 a Med Access report 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.)