

**Objective**

HMA was engaged by Berkshire Fallon Health Collaborative (BFHC) to Support evaluation of post admission transition of care (TOC) processes in the ambulatory setting to improve TOC completion and communication to PCPs post discharge. HMA was also asked to support evaluation of post ED TOC processes for Medicaid patients in the ambulatory setting to improve TOC completion and communication to PCPs post discharge.

**Observations and recommendations for improvement are summarized under the following five key principles:**

1. Patient-centered transition support, as previously noted

2. Shift appropriate care form hospital and emergency departments to primary care,

3. Focus on improvement of clinical quality and patient care,

4. Establish cross-sector collaboration with defined accountabilities, and

5. Enhance data sharing across industry sectors through consistent risk assessment and automation of information flow.

**Recommendations:**

1. Engage patients and family in partnership to develop a self-care strategy in preparation for discharge

* 1. 2. Deliver evidence-based education to patients and verify comprehension

 a) Ensure patients understand the importance of follow-up with primary & other care

 b) Engage patients and families in discharge planning and education

 c) Ensure patient has a clear contact to call for immediate post-discharge needs

 d) Activate patients to recognize early warning signs (“red flags”) and have an action plan

* 1. 3. Deploy a consistent Medication Review and Reconciliation process
	2. 4. Transition record/Discharge plan – teaching, reaffirming, verification, identification of barriers
	3. 5. Make follow-up appointments by entity with best patient relationship, on behalf of PCP:
	4. a) Develop automated or self-reported assessment of patient relationships
	5. b) Identify and mitigate barriers to follow-up
	6. 6. Apply AHRQ IDEAL Discharge Planning elements
	7. 7. Develop process for care plan development which is patient-centered, and provider supported

**Medication Reconciliation Cross-Sector Example Workflow**



**To engage patients/families in discharge planning and education and ensure they are confident that they can perform self-care at home, the following process should be considered:**

* Provide a patient-centered discharge action plan:
	+ Patients & family write on form primarily (if able)
	+ Does not replace discharge instructions, but would benefit the process if the discharge instructions mirrored the structure of the patient-centered discharge action plan
	+ Form is kept at bedside with extra’s forms available as needed
	+ The care team reminds patient & family to take notes on the form and reminds them to write down non-urgent questions to be discussed prior to discharge
	+ At discharge, review all 5 sections of worksheet as well as the discharge instructions:
* Activate patients to recognize early warning signs (“red flags”) and have a plan to address them.
* Medications to start/stop or change
* Follow-up appointments that are scheduled or need to be scheduled may also include outpatient labs or testing
* Results for follow-up to ensure the patient knows what the next steps are in their treatment plan
* An open invitation to record questions they may have or information they may need prior to discharge
* Clearly review the medication schedule, last dose(s) taken, when the next dose(s) are due and be sure patient has new medications needed.
* Remind patient/caregiver of nurse availability 24/7 - Ensure each patient has a clear contact to call for immediate post-discharge needs prior to attending their post-discharge follow-up visit. It may be a hospital staff person or their PCP if sufficient communication has occurred with the PCP prior to patient discharge.
* Ask if you can have a copy for the chart and upload into EMR.
* To support this process, please find a best practice example of Anne Arundel Medical Center’s Plan For A Smart Discharge: S.M.A.R.T.SM Discharge Journal and Protocol. It could be used to develop a BHS version to provide to every patient to record their understanding of key elements of their discharge instruction.



**TOC Contact Post Discharge ‘Ask Me 3’**

The TOC contact post-discharge should reinforce the importance of the follow-up appointment and primary provider relationship. Any entity providing follow-up care, should introduce their efforts as “on behalf of your PCP” or “your PCP asked me to call”, which requires tight communication with the PCP. The call should verify that the follow-up appointment has been made, is still at a time when the patient can attend and identify and mitigate any barriers to attendance as may have occurred since originally scheduled. The call also provides an opportunity to prepare the patient for the visit. Consider the use of preparing the patient to ask key questions such as “Ask Me 32”

[Ask Me 3: Good Questions for Your Good Health | IHI - Institute for Healthcare Improvement](http://www.ihi.org/resources/Pages/Tools/Ask-Me-3-Good-Questions-for-Your-Good-Health.aspx)

**Best Practices for Post-Admission Documentation, Efficiency & Reducing Duplication**

A systematic approach to the discharge process involving patients and caregivers and all providers in the continuum of care. Promising practices and evidence-based models provide the basis for consideration as BHS defines a path forward to ensure high-quality, cost-effective transitions. HMA reviewed multiple models including the following:

American Medical Association, There and Home Again, Safely: 5 Responsibilities of Ambulatory Practices in High Quality Care Transitions <http://www.ama-assn.org/resources/doc/patient-safety/ambulatory-practices.pdf> 2013

Center for Healthcare Research and Evidence-based Programs, Care Transitions: Best Practices and Evidence-based Programs, January 2014: <https://chrt.sites.uofmhosting.net/wp-content/uploads/2014/01/CHRT-Care-Transitions-Best-Practices-and-Evidence-based-Programs-.pdf?_ga=2.86292828.571379536.1619120971-999331931.1619120971>

New York State Partnership for Patients, Preventable Readmission Initiative: <https://www.nyspfp.org/>

Project Boost Implementation Guide 2nd Edition, 2013: <https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf>

Transitional Care Model: University of Pennsylvania School of Nursing New Courtland Center for Transitions and Health <https://www.nursing.upenn.edu/ncth/transitional-care-model/>

Institute for Healthcare Improvement: Transforming Care at The Bedside: <http://www.ihi.org/Engage/Initiatives/Completed/TCAB/Pages/default.aspx>

The Care Transitions Intervention <https://caretransitions.org/about-the-care-transitions-intervention/>

Project RED (Re-engineered Discharge) – nurse discharge advocates met with patients before discharge, made follow-up appointments, and communicated discharge summaries to PCPs. Pharmacists called patients 2-4 days after discharge to review medications. <https://www.bu.edu/fammed/projectred/toolkit.html>

**Recommendations** relative to patient education opportunities:

* Assess how well-prepared patients are to take care of themselves following an inpatient stay. Consider asking 2 questions to all patients being discharged (or receiving TOC calls after discharge) for one week:
	+ How confident are you that you can manage most of your health problems? Very confident, somewhat confident, not very confident, or does not apply
	+ How would you rate the health information you received from your doctor or nurse? Excellent very good, good, fair, poor, or I didn’t receive any information
* Consider use of patient education materials that can be tailored to the patient’s needs. For example:





Recommendations relative to the Accuracy of PCP Assignment:

* Develop a centralized location to post a sortable list of primary care providers who are accepting new patients, with specialty (pediatrics, family medicine, internal medicine, geriatrics) and practice location. Establish a process to keep it continually updated. Provide access to this information to admissions staff, ED registration staff, care managers, community partners, VNA staff, and other sites of care.
* Develop a patient panel “look-up” function enabling verification of patient reported primary care provider with limited access to ED, admission staff, and others designated by BHS.
* Document a standardized process for making a primary care change including notification of the practice, insurance plans, and system administrators for relevant electronic platforms. (For example, if the patient is a Medicaid member in BFHC who changed their provider to a CHP primary care provider, the following notifications would be needed: MassHealth, Fallon Health Plan and BFHC for TruCare, CHP for Athena, MediTech Expanse Acute for the current visit/ admission.)
* Ensure all patients entering the ED or being admitted are assigned a PCP by asking the patient, verifying the information with the practice/patient look-up system, or helping the patient select a PCP and completing the process of notifying the insurer and practice. Hospital should have access to an updated list of practices open to new patients.

**Transition of Care Workflow for Medical Patients Without PCPs**



* Upon admission or presentation to the ED, all patients are asked to identify their PCP and admission, or ED staff verify this with practice/patient look-up feature.
* If patient reported PCP is confirmed within the system, the provider is documented, and the admission or intake process continues
* If a discrepancy is noted in the information provided, the patient is informed and corrected with information available, if possible (such as patient produces documentation from their provider), or a call is made to the providers to identify correct assignment
* If the patient states that they do not have a PCP, the patient is offered an appropriate provider accepting new patients who is located near their home or work. If acceptable to the patient, the process for making a primary care change is followed to ensure notification of all appropriate entities is completed.
* If the patient states that they have a PCP, but do not plan to continue with their PCP, the process for making a primary care change is followed to ensure notification of all appropriate entities is completed, with special attention to the originally assigned PCP
* Once primary care provider has been confirmed, notify of current ED visit or admission, and follow the appropriate TOC process.
* Formalize a process whereby the practice reaches out to the patient within 24 hours of discharge from the ED to cultivate the new patient relationship, schedule a timely new patient visit appropriate to patient need, and address follow-up care needs.

Recommendations relative to the Release of Information:

* Ensure ROI is signed by patient prior to discharge to share information with the PCP, BFHC, CP, and other providers involved in the patient’s care.
* Implement a ROI Campaign implementation system-wide – HMA recommends development of an organized, consistent approach to patient education at every level of the BHS system including scripts to guide staff in obtaining and documenting consent to care management and release of information to care managers and primary care. Patient education could center on the benefits of information sharing to enhancing care, the protections in place to protect their information, and the importance to patient safety. Standardized messages in the form of talking points should be delivered at every interaction with the system – reinforced by primary care, outpatient services, ED, and admissions. Dedicated effort of the staff of McGee to obtain ROI/releases for BFHC, BHCP, and primary care as part of admission process and communication of the ROI to appropriate parties would facilitate communication and make services immediately available for the member, including timely transition of care calls and follow-up visits.

**Transition of Care Workflow for Patients with SUD**

The biggest barrier to effective transitions of care for patients discharged with substance use disorder is lack of signed release of information forms limiting timely notification and information flow to outpatient providers and care managers.

An community-wide opportunity exists to build trust through education of providers, patients, and the community to the benefits of information sharing, the protections in place to maintain the confidentiality of health information – including SUD, the importance of seeking treatment for addiction, and value of these efforts to the community.



Workflow Detail

1. Prior to admission, all patients are provided information about the value of information sharing (Patient Information brochure including talking points referenced above) and a copy of the ROI form along with recommendation that they consider releasing information to all of their healthcare providers, including their primary care provider, primary therapist, specialist, BFHC, CP, and any other provider – tailored to the patient. This information should be mailed to every patient with a scheduled admission and reinforced by all healthcare providers. Provide an option for those with on-line documentation capability to upload completed forms.
2. At admission, all patients, whether scheduled or not scheduled, should be provided information about the value of information sharing (Patient Information brochure including talking points referenced above) and a copy of the ROI. Admissions staff should provide patient education regarding the importance and value of releasing information, privacy protections, etc. and ask the patient if they would be willing to sign the ROI form. a. A designated location in the EHR should be implemented to capture ROIs signed with appropriate detail such as parties authorized and dates of validity.
3. Admissions / ED registration staff should document completion of ROI and upload the signed form.
4. During admission, patients should receive similar messages based on talking points and be encouraged to consider sharing information if they have not yet signed the ROI. a. Inpatient CM should encourage signing of ROI and document completion of ROI and upload the signed form.
5. At discharge, the inpatient CM or discharging nurse should conduct discharge teaching and revisit the importance of sharing information with the members of the patient’s care team, including primary care provider, primary therapist, specialist, BFHC, CP, and any other provider who are part of their discharge plan. a. Staff should document completion of ROI and upload the signed form.
6. Electronic entry of signed ROI should trigger notification of authorized healthcare providers and allow download of the signed ROI form into their systems. a. Upon notification, follow TOC protocol with BHCP likely taking the lead in coordinating substance use disorder treatment and supportive services

**Protocols with Metrics and Standards for TOC Calls**

**Performance Assessment Tool**

The protocols, metrics, and standards required to support a Continuous Quality Improvement process relative to post discharge transitions of care should have a primary goal of answering three questions under a transitional care management strategy:

1. How well are we managing transitions to home? a. Set a benchmark goal based on best practice & past performance to set reasonable target and measure against it
2. Where are we not applying best practices to prevent readmissions? a. What interventions are not being applied well or not preventing readmissions
3. Where do we need more resources focused to prevent readmissions? a. Do we need Training, Staffing, IT, Deeper Analytics, etc.

These questions require a comprehensive analytic model that is derived from workflow elements and an IT infrastructure designed to track key interventions such as post discharge calls. The sample performance assessment tool below is designed to measure global outcomes, best practice workflow elements, and to provide deeper insights to inform operational enhancements to improve outcomes.

**TOC Post-Admission Performance Assessment Tool**



**Post ED Workflow**

**The following table describes the post-ED transition of care workflow elements across staff and setting.**





**Improving the Emergency Department Discharge Process: Environmental Scan Report**

AHRQ’s Emergency Department Discharge Process Environmental Scan Report describes three main functions of an effective ED discharge process as follows:

There are several interventions cited as potential improvements to the ED discharge process, three of which were correlated with higher levels of success: discharge instruction education/simplification, telephone follow-up, and ED-made appointments.

* Discharge instruction – ED providers effectively communicating critical information, verifying understanding, and tailoring to meet patient needs enhance safe discharges.
* Follow-up Telephone Calls – found to be effective in reaching patients and clarifying discharge instructions
* ED-made follow-up Appointments – resulted in higher follow-up appointment rate vs. just providing the practice phone number.

[Improving the Emergency Department Discharge Process: Environmental Scan Report (ahrq.gov)](https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/edenvironmentalscan/edenvironmentalscan.pdf)

**Recommended Workflow for Post-ED TOC Completion Including Integration of non-RN Roles for Medicaid Patients without Established PCPs**

Healthcare professionals interviewed consistently reported the lack of Registered Nurses (RNs) available in the community for workforce recruitment. According to the 5/26/21 MassHire Berkshire Workforce Board Fact Sheet, 400 open jobs were reported in Healthcare out of 2,537 open positions in the county – the highest need industry listed. Among the top industry-specific skills needed were nurses.

In addition to the lack of nurses available in the job market, they are an expensive resource. According to Indeed, the average hourly pay for a BHS registered nurse is $ 45.22 per hour, which is 27% above the national average

According to the County Health Rankings, Berkshire County is ranked among the least healthy counties in Massachusetts and in the lower middle range of counties in health factors. Health factors include health behaviors, clinical care access, social and economic factors, and the physical environment. To the extent that a population has more barriers to good health, the greater the need for a flexible workforce able to address medical and non-medical health factors and the social determinants of health.

Massachusetts allows a variety of non-Registered Nurse roles to support health and wellness activities including Case Manager/Care Coordinator, Peer Recovery Coach, Peer Support Worker, Peer Recovery Coach, Certified Addiction Recovery Coach, Certified Peer Specialist, Recovery Support Navigator, Recovery Specialist, Certified Prevention Specialists, Medical Assistants, Nurse Assistants, Licensed Practical Nurse, Social Worker, and Community Health Worker. There are other positions serving in clinical support roles such as Clinical Health Educators. Licensing entities and required training vary by role:

* Certified Prevention Specialist Requirements: <https://csps-ma.org/> certification
* Peer Recovery Coach Requirements: [https://careersofsubstance.org/your-career/career-paths/peer-recovery coach#:~:text=have%20lived%20experience%20of%20addiction,volunteer%20providing%20Recovery%20Coaching%20services](https://careersofsubstance.org/your-career/career-paths/peer-recovery%20coach#:~:text=have%20lived%20experience%20of%20addiction,volunteer%20providing%20Recovery%20Coaching%20services) Massachusetts Board of Substance Abuse Counselor Certification (Private, nongovernmental entity)
* Peer Recovery Coach, Certified (Mental Health) Peer Specialist, Recovery Support Navigator, Recovery Specialist – Massachusetts Department of Public Health Bureau of Substance Addiction Services (DPH/BSAS) 2/27/19 Peer Support Worker Comparison Chart: <https://www.mass.gov/doc/peer-support-worker-comparison-chart/download>
* Social Worker Requirements: <https://www.mass.gov/social-worker-licensing> - Board of Registration of Social Work
* Community Health Worker Requirements: <https://www.mass.gov/community-health-worker-certification> - Massachusetts Department of Public Health Board of Certification of Community Health Workers
* Certified Case Managers/Care Managers/Care Coordinators: <https://www.netce.com/ce-requirements/certified-case-manager/ma/>

Massachusetts also supports programs such as Behavioral Health (BH) and Long-Term Services and Supports (LTSS) Community Partners (CPs) to provide care management and care coordination services to specified populations.12 CPs can serve as an important patient support and care team member, but require information sharing across organizational lines to be effective.

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