Data for Quality Improvement: Working with our Hospital Partner on QIP Access and Integration Goals

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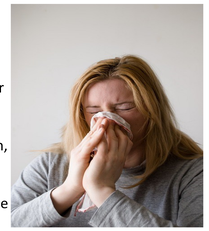
Background

Health Quality Ontario (HQO) has established three primary care indicators that provide some measure of a FHT's ability to assist in increasing efficiency in hospital utilization. The first indicator is the percentage of patients who see their primary car provider (PCP) within 7 days of hospital discharge. Good performance in this area presumably decreases the percentage of patients who are readmitted to hospital within 30 days of discharge, which is the second indicator. The final indicator is the percentage of patients who attend the Emergency Department (ED) for conditions best managed elsewhere; i.e., through their PCP.

There are a variety of reasons for patients to be readmitted to hospital, some of which have little to do with primary care (e.g., premature discharge, hospital acquired infections). However, primary care has some control over medication errors that may result in readmissions.

We know that when complex patients are discharged home, they are in a highly vulnerable state. Studies show that they are at high risk of having an adverse event. Medication errors are the most common and most of these are preventable. At SETFHT, our focus of the 7-day discharge appointments and hospital readmission indicators has been on medication reconciliation to prevent medication error that may result in a hospitalization. While the high-level goal is to improve patient safety for our most complex patients, we anticipate that readmission rates could be reduced by preventing medication error.



There are also many reasons patients attend the ED for conditions best managed by their PCP. The Case Mix Group (CMG) includes: conjunctivitis, cystitis, otitis media, and URIs). At SETFHT, we have our suspicions that many of our patients do not appreciate that we have same day appointments available, that we are open Monday to Thursday until 8 pm, and that we have a weekend urgent care clinic. In order to identify improvement activities, our focus has been on better understanding why our patients attend the ED instead of coming to the FHT.

SETFHT is in a somewhat unique position among Toronto FHTs in that the majority of our patients attend just one hospital, Toronto East General Hospital (TEGH). Information sharing from TEGH has made it possible for SETFHT to identify individual patients who have had hospital involvement and in doing so, either track our progress in the HQO indicators or contact patients for more information. It is difficult to imagine how we might establish improvement activities if we were to receive information about our performance in these indicators only once a year through Health Data Branch. Information from TEGH has provided us with the basis for our QI efforts and our ability to measure change.

For more information about Hospital Report Manager: https://www.ontariomd.ca/portal/server.pt/community/hospital_report_manager

How It Works

Hospital Report Manager

- We have developed a process using HRM and our EMR (Practice Solutions) to track hospital discharges for the purpose of offering patients immediate follow up appointments, and to complete medication reconciliation in the chart before the patient attends for their next appointment:
  - TEGH shares discharge data via HRM on a daily basis. HRM electronically delivers text-based medical records reports from TEGH directly to SETFHT patient records, alerting PCPs of patient admissions and discharges.
  - The HRM reports are reviewed every few days by the SETFHT Care Navigator for those patients in the HQO-defined Case Mix Group, as well as patients with mental health admissions (a reasonably large percentage of our patient population that we wanted to follow). Patients are encouraged to attend a PCP visit and for those who do not already have an appointment, the Care Navigator contacts them to offer one.
  - The Care Navigator also identifies patients within the CMG who have had medication changes in hospital and forwards those reports to our Clinical Pharmacist.
  - Our Pharmacist completes medication reconciliation in the EMR and then messages the MD or NP with an alert about the changes.

Report on ED Visits

- TEGH had been providing SETFHT a daily list of our patients who attend the ED (the reports are sent via HRM). TEGH agreed to add the patient's CTAS (Canadian Triage and Acuity Scale) score to the list.
- We use this information to identify patients to send a survey about their decision to go to the ED instead of calling the FHT.
- Although the list of conditions considered to be best managed elsewhere is narrower than the conditions that fall under CTAS 4 and 5, we decided to send our survey more broadly to better understand our patients' decision-making.
- The survey includes questions about:
  - Whether they tried to get a same day appointment and if not, why not.
  - If they tried to get a same day appointment, what happened.
  - If it was after hours, did they call our Telephone Health Advisory Service or did they think about waiting until the morning to call the FHT.
- Our Patient Advisory Council reviewed the survey questions to ensure the tone and content was not accusatory and would encourage completion of the survey.

Outcomes

- Since Feb 2015,
  - 84.6% of patients have been contacted within 7 days of discharge from TEGH.
  - 96% of patients have been contacted within 14 days of discharge from TEGH.
  - 22.5% of our patients admitted to TEGH were not discharged home or referred to a specialist (e.g., sent to Long Term Care).
  - 1.6% of our patients admitted to TEGH died in hospital.
  - 12.4% of our patients discharged from TEGH were readmitted within 30 days; the range was 2-30 days for readmission.
  - For patients readmitted, 66.7% had a primary care visit at SETFHT between their TEGH discharge and readmission.

Many thanks to our Care Navigator, Danielle Del Duca, and our Clinical Pharmacist, Kaila MacMillan, for their work in this program.

- We sent surveys in September 2015 to 99 patients who attended the ED since April 2015 with a CTAS score of 4 or 5. Our response rate was 16%.
- None of those who responded fell into the category of conditions best managed elsewhere.
- 5 responded that they required imaging for possible fractures; 2 told us they were sent to the ED by their physician (family physician or specialist).

Challenges

HRM:

- At this time, SETFHT receives electronic medical records only from TEGH. Our patient population, although primarily based in East York, lives throughout and even outside the GTA. This means we still experience challenges in receiving hospital reports and discharge summaries in a timely fashion from other hospitals and we have no formalized method for ensuring medication reconciliation with non-HRM reports.
- One of the goals of the 7 day post discharge follow up is to avoid unnecessary readmissions. However, we are still seeing recently discharged patients being readmitted soon after. This raises questions about:
  - The level of community support available to medically complex patients.
  - Whether some patients are being discharged too soon.
  - The availability of mental health support in the community.
- HRM reports have made a significant positive impact on our patients; the reports do not always include medication lists, resulting in the need for follow up communication with the hospital (and our slightly less than 100% medication reconciliation rate).

ED Visits

- TEGH has provided us with the CTAS score in ED reports; however, it is not in the HRM report and therefore is not automatically inputted to the patient's chart; this information has to be manually entered.
- We have emails for only about 1/3 of our patients who attended the ED since April.
- To date, those who have responded to the survey do not fall into the CMG that are being examined.

Future Directions

For discharged patients:

- We would like to take a closer look at our discharged patients who had a subsequent hospital admission to determine:
  - Which patients were admitted for new conditions vs. readmitted for the same condition.
  - The characteristics of readmitted patients who had an appointment with the PCP prior to their readmission.
  - Which patients may have been discharged prematurely and what may have led to the discharge.

For ED visits:

- For those without an email address on file, we will send a letter with a link to the on-line survey.
- We plan to collect data until the end of the year in an effort to identify QI opportunities.