Good afternoon, everyone. Welcome and thank you for joining our monthly webinar, orderly webinar for the hospitals. Today we are talking about connecting with primary care, learning about the IMPACT project. Before introduce the speakers, I will go over logistics. Today session is being recorded and will make the recording slides available on the web site shortly after the conclusion of the call. As always, we will have a short evaluation that will pop up at the conclusion of the call. We ask that you answer the questions these those tests when you see those in the pop-up message after the call.

All lines are muted in listen only mode. However, if you would like to participate, please chat in any questions or make comments using the chat feature and we have a nice little graphic showing the control panel. Right under the attendee panel, you'll see the chat tab, and you can toggle on that to type in your chat question. We will do a quick test of chat capabilities now. We ask that you chat in the name of your hospital and how many are participating with you today. So, we will give a few seconds to complete that exercise. It is always good to see who we have on the line.

Also, if you are calling you over the phone, you can unmute your line to ask questions. Please note yourself and the hospital from which you're speaking. Great, I am seeing some hospitals chat in the hospital names and participants. That is wonderful. We do ask that you check into all participants whenever you can. That allows everyone on the call to see those questions and comments coming in, as well as the presenters who are presenting off-site. Great.

So today, it is our pleasure to have two guest speakers today. First, we will have Dr. Sam Cykert. Dr. Cykert is the associate director of medical education for the North Carolina AHEC program and the clinical director of the North Carolina regional extension Center for health information technology through AHEC. Dr. Cykert will be presenting on the impact project, the care transition project in primary care, we are also pleased to have Liz Riley, a physician assistant from the Roxboro family medicine practice will also be speaking with Dr. Cykert.

So before we turn it over to Dr. Cykert, Laura Maynard, the director of collaborative learning for the quality center has updates to share.

I wanted to give a quick reminder and context for today's presentation. The mission, the overall goal of our collaborative that we are participating at this point is to improve transitions in care and thereby to reduce the affordable hospital readmissions. And a reminder, the goal of our collaborative, overall we are looking to reduce readmission rates by 20%. But, we have also listed our process measures that we are hoping will get us to that outcome. And probably have looked previously at assessing the risk of readmissions, we want to particularly focus today on the ones that are in bold. And that has to do with connecting with primary care physicians. So, one of our process measures is that if you're patient in your pilot unit that is assessed to be high risk of readmission, that you would inform their primary care physician after hospitalization
within 48 hours of admission.

And also that the patient in the pilot unit who are assessed to be a high risk of remission, that their follow-up visit with the physician needs to be scheduled within seven days of the discharge. So, those are the measures we are currently focusing on today. Our methods within the collaborative, as a reminder, certain things we are doing within hospital setting, other things to your community setting because it does take both sides of that in order to really, truly improve the care transitions and reduce the readmissions. So within the hospital the Houston assessment of readmissions in value stream map of your discharge process and you're working on targets and improvement in those four key areas of better care within the hospital.

In that unity, we are encouraging you to participate in that community engagement assessment and our previous webinar was about that. To identify and connect with your local community organizations, services and practices and the meetings of the cross continuum team and to conduct a root cause analysis focused on the care transitions in your community.

So, those are the overall collaborative methods that we are undertaking, and so at this time, I want to turn things over to Dr. Cykert who is going to speak to us about the IMPACT program.

Hi, first of all, I just wanted to say it is a real pleasure to get the opportunity to speak to all of you. I know that your game about readmissions as the implications on your health system and, you know, how it affects things financially. But, one thing I want you to know is that there was a study published in the Journal of Internal Medicine at the end of last year that showed that the actual mortality rate for patients readmitted to the hospital within 30 days of decks a admission was three times that of a morbidity age matched population that wasn't readmitted in 30 days.

So, this is not just a story of readmission and money, it is a story of patients who are on a slippery slope of severe disease, who are very frail, and it is making sure that they have the patient support needed to keep them from falling down the hill, in step, regain their footing and going on to health.

And as you all know, the study republished in the New England Journal a couple of years ago by Jenks showed that of all Medicare medical readmissions, 20% were readmitted within 30 days, and half of those did not their primary care doctors or had any outpatient visit before they were readmitted.

Now, on this initial slide, I just want to point out, Darren DeWalt was the principal investigator for the IMPACT program. We had a lot of help from many, but I wanted to recognize Jennifer Cockerham, Laura from AHEC and Lynne Taylor and Christine Jones for all of their dedicated work on the project. I am sure that I skipped many but I wanted you to see those few names.
So, IMPACT was a project where we were really doing to name -- two main things. First of all, we did have a regional leadership collaborative where we worked with physicians and others in different regions of the state on working together to be able to do mostly quality improvement work, but change management was that all of the things coming down the pike in healthcare these days. And, the other part of the project was to integrate care transitions to the work of primary care practices. Again, I bring up that Jenks study. When you think about a sick patient in the hospital you're talking about a person who was seen by a physician every single day for acute illness over several days. Then, all of a sudden, they are home and, bam, you know, who is watching over them? Who is making sure that they continue to make their recovery?

So particularly for high risk patients, it is really important to have the idea of a warm handoff from hospital care to ventilatory care in order for things to go smoothly in that recovery. So, in our care transitions projects, we had nine practices that participated. There were coaches from both AHEC and community care who worked with the practices to build the systems that help doing good transitions work. And, we managed the system, as you do, through a monthly webinar and every month, we got reports from all of the practices. But, the other thing is, we used the IHI STAAR Guide as a place to start but also went through the medical literature and found some other good evidence-based guidelines for practices to help them along the way and take good care of these patients.

So, we get started up in these practices and we think, oh, well you know, getting these patients in, that won't be so hard. And having good approaches to care won't be so hard. But, we were in for a bit of a rude awakening in that communication between hospitals and the practices were very inconsistent regarding admissions and ED visits. Not only for the system, I mean, some of our practices were sort of in little areas of systems and their patients went to several different hospitals. And so they had to deal with multiple systems to hear about their patients.

But even within big healthcare systems who are on the exact same EHR, this system as information was not necessarily consistent. And the other thing is, neither the practice for the hospital consistently risks stratify patients at the time of discharge to really, really emphasize, you know, the patients that were in the most danger of, sort of, falling down this slippery slope at high or moderate risk.

And then finally, the practice policies themselves were inconsistent in dealing with these patients. Many practices sort of took the approach that, well, I have this mass of patients, and whether it is a hospitalized patient or not, the patient gets to their place within the alignment, within the queue, and we don't necessarily prioritize these hospitals discharge visits.

Now, on this idea of risk stratification, you know, identifying a high risk patient, you think, oh, there are all of these computer systems and who can afford all of that software? Well, when we set up our system at UNC, you can see that the algorithm was very, very simple. And looking at the high-end moderate classifications, patients that fell within the range of -- accounted for over 90% of readmissions within 30 days. And so, those with the patience we decided to really make sure that we got into our general medicine unit
quickly.

So the bottom line is, identifying risk on the hospital side or the clinic site isn't necessarily complicated. So thinking about more of these lessons. You know, we have these practices that weren't getting to send information from multiple hospitals. And so we decided, well, what can we control up front? So we asked each practice to pick the hospital that admitted most of their patients and to really hammer a system of information between the practice and that hospital.

But then, even once we establish that system of communication, the next poll on the system is, okay, we get the patient in within seven days, well, where is the discharge summary? Or is anybody talking to anybody? So, having an idea of what is the purpose or the exact problem or need for that visit, we really need to emphasize a discharge summary being ready for one practices were ready to take the warm handoff on that patient.

Another thing we learned was that many patients get the information about practice hours, maybe once early on when they joined AIPAC this. But, patients were totally ignorant about any standard hours practice had, and they were also very ignorant about -- ignorant, not a good work, but they were also uninformed about after-hours care. And so, one point of the system we took on was this idea of constantly educating patients about these hours issues. And then another thing that happened early on was that patients coming out of the hospital did not understand the value of a quick follow-up visit. They had the feeling of, well, I just got out of the hospital, I am still kind six. Why should I go -- I am still kind of sick. Why should I go to the doctor's office? Another theory that needs to be taken up on the hospital side is educating patients asked why they ought to get in with their outpatient physician for that warm handoff, and then finally, another thing was that the Medicare transition codes are significant and actually knowing that the practices are going to get paid some for this work and knowing how to use those Medicare transition codes, we found that to be very important.

So other things we talked about were the formatting of hospital follow-up visit. We emphasized, particularly with Medicaid and to eligible patients, the superb care management system that DC and see -- that CCNC had for the patient but we also talked about options for non-Medicaid patients. And we really emphasize medication reconciliation for two angles. Number one is depending on what you read between 15 to 25% of patients leave the hospital do not fill their new medication prescriptions at the time of discharge. And so, medication reconciliation is important for those new medicines, but on the other, think about a patient, for instance, who comes into the hospital with a vomiting illness. And that patient has congestive heart failure. Well, they come into the hospital hypotensive and vomiting. Their diuretic medications are stopped so that their fluid status can recover, but then, when they go back to the ambulatory care practice, somebody has to take responsibility of saying, hey, the patient is not vomiting anymore, so I need to restart those old medications. So, Medicaid reconciliation -- medication reconciliation is important for those new patients in the hospital and whether or not it is justified to stop old medications that have been stopped during the hospitalization.
And then, we really emphasize the idea of the teach back. That you need to make sure that the patient understands the three or four major points that you are really trying to get at, and that the teach back is a skill you can make sure that the patient or their family member has that understanding. And then finally, that one visit when the patient comes back to the practice when they are really, really sick does not necessarily mean that the patient is going to do great after that.

And so, the practice has to be able to assess whether or not the high-risk situation continues. And again, for the high-risk patient, it is this idea of enhanced access. Ms. Jones who is a really frail and really sticks, if she calls, we need to figure out a way to deal with her problem. Because if we just, I can, put her in the general population queue, and she can't get into the practice or get through on the phone, and she is going to crash and end up back in the ED and back in the hospital.

Now, this slide just shows you, we did create checklists for what things ought to happen when the patient comes back to the practice. And so, this is just an example of a general nurse MA checklist for post hospital visits. This is a provider checklists. About going to the details, suffice it to say there are certain-that ought to be hit on all of these visits. And for certain high-risk illnesses, for instance, like congestive heart failure and COPD, we also have some disease specific checklists.

So what happened as a result of all of this? You know, this program has been going on now for about a year. And I can tell you that in all of these practices, there were substantial changes and that every one of them had a consistent information system set up with at least their highest admitting hospital. They all had a system of bringing these, at least the highest risk patients, within a week. And they all used visit plans that, again, foster identifying these high-risk patients and keeping them out of trouble. And every one of them really emphasized these after-hours plans. So, those were things that happened in every single practice and other practices even went on to do some more sophisticated things.

And then, the other thing we got out of the work is these -- we generated ideas of how to implement these systems and different types of practices and the AHEC and CCNC coaches really learned both this system of care and how to get it across with the practices. So just to give you an idea of a little bit of data, so, when we started this program at UNC, despite the fact that the inpatient side in the outpatient side was on the same medical record, there was no systematic way to risk stratify the patient's and informed the press this about the patient. -- And inform the practice about the patient.

Physicians got an e-mail about a patient being in a hospital, but not a systematic way to get the patient into the pack is. -- Into the practice. So as you can see, looking at the left side of the upper right-hand graph, the number of hospital follow-up of clinical appointment has grown substantially per month over the last year. And, the no-show rate for these patients has gone down considerably. And our initial data shows that the number of 30 day readmissions, basically got cut in half and the number of 90 day readmissions fell about 12%. 
And then this graph is a little bit hard to read. These are control charts. But, if you look all the way to the left, the number of the percentage of admissions that were we at minute work -- that were readmitted, were consistently between 17 and 23% per month. Now that number is down consistently between 8-10% per month. So, what this tells me is that these systems work and the main thing that we did here are the exact same things that I just told you about. We made sure that we knew about the admissions. We made sure that we stratify them. We made sure that the high-risk patients got him within a week and the moderate risk patients within two weeks. And then reapply the other principles, which is, medication reconciliation, making care management available for patients that qualified.

You know, we did all of those things that I showed you on the last few slides. And it worked. So as a result of this iterative practice, we have actually gone ahead and we have kept track of all of these process changes along the way. We adjusted the plan of implementation, based on a pack of full concerns that we learned -- based on the practical concerns that we learned. And so we basically created a change practice with all of these things that I talked about and we have published it in a guide in PDF form. And there is the front page. There are the acknowledgments.

And before I get to the conclusions and talk a little bit more about the change package, you know, you heard about some of the data and some of the changes that happened at real big place at UNC, but Roxboro Family Medicine isn't as big as UNC. It is a small practice in a small town and they rented their changes in the way that they could make it happen in their unity. So I want to go ahead and bring Liz Riley on board to talk about that.

Thanks, Dr. Cykert. Hello, everyone. I want to thank everyone for their interest in care transitions and signing on today and think Dean and Dr. Cykert for having me be a part of this discussion and a special thank you to Lynne Taylor and her help through this project. Let me go to my first slide.

So, despite this being over a year long project, I tried to squeeze down into a few slides, the overview discussing a few major steps that we took. You see how this follows along with the information that Dr. Cykert has already presented. Our first step was started by evaluating and understanding the current process that we have in terms of one of our patients for being admitted to an hospital discharges. The first step is to get admitted and we were sometimes notified or sometimes not. Once they are discharged, and during that time that the patient was in spittle, it is purely -- was in the hospital, it is fairly rare that we would get information while they were hospitalized.

At the discharge, often we were unaware that the patients were discharged. If we were aware that appointment was made by some clinical person at the hospital and we actually did not have a specific appointment that was termed a hospital follow-up. It was just a regular follow-up and the details of that visit were notified that it was going to be a hospital follow-up. And also realize that we really do not have a good risk stratification process for recent discharge patients. When the patient finally did come in for their -- oh, go back. There we go. That's all right. When he did come in for their hospital follow-up visit, we had a discharge summary available and that was one of the biggest frustrations
of the providers in our fact is. -- Practice. Often times, easily 90% were not available at that visit, the mentor brought and two things happened. One, the patient potentially transitions or, they were admitted back into the hospital at some point in the future.

So, we try to evaluate where the breakdown was happening. And obviously, they were not notified of the patient being discharged. Did hospital know that we were the primary care provider and if we were notified, didn't get in patient specific information or communication from the hospital, being a phone call from hospitalists or a discharge summary. With that, it felt like there could be breakdown on multiple fronts. One, either the discharge summary was completed by the time of the appointment. But not sent by the hospital. And really, whose responsibility was that to get that in permission from the clinic or from the hospital? And the patient was unaware of the importance of that visit and we felt that it was certainly our responsibility to make contact with the patient and reiterate the importance of the visit.

We ended up having the nurse who typically care for the patient when they were here call the person because of that established relationship. If the patient does not understand discharge instructions given, that is when we worked on standardizing teach back and medication reconciliation and then passed that, whether or not the patient was able to get their additional services, be it at home health, appointments with specialists, things of that nature. Next slide.

So we felt like the first thing to do was to see internally what needed to do. What needed to change and come up with a process for these particular types of visits. And so, we decided that upon notification of the discharge, we would make our hospital follow-up appointment, we made a 30 min. visit, specifically documented as a hospital follow-up so that providers and nurses would know what the patient was coming in for. And upon notification of the discharge, the front office automatically requested a discharge summary from the hospital and created a note in our electronic health record and routed back to the nurse who typically checked the patient.

The next step would be the nurse making the contact with the patient which was our first phone call prior to the hospital follow-up appointment, and again, emphasizing the importance of them keeping that important. Josh appointment. When they arrived at the hospital for a follow-up appointment, we try to make this. Standardized visit him at the same thing happening each time. We took this checklist that Dr. Cykert talked about and integrated those into our electronic health records and made a quick electronic template automatically put in at each visit. For teach back into those types of things. We made quick text work adjuster -- quick text for congestive heart failure and COPD integrated easy to cover bases on each visit each time. At that time, the discharge summary should have been in the chart and that would give us a chance to follow up on any maps or testing or services that need to be arranged.

Once the patient left, and actually I will go back to that first call that the nurse made. Because that nurse knows the patient and experienced them in previous clinical visit, typically, they were able to assess whether the initial appointment, whether that be three days or seven days out, if that needed to be [ Indiscernible ] based on an initial contact. We would make some backup appointments, maybe one or two days, rather than three
or seven days out. After follow up phone call which happened one to two weeks after the hospital follow-up visit, the nurse will evaluate what was happening on the patient and sent any information on to the physician PA assisting them and make sure that nothing was needed at that point.

If it was a high-risk patient, often that would be a follow-up visit rather than a phone call and then would have another phone call 2 to 4 weeks out and communicate continuously with home health making sure specialists visits were done and that the patient does not have any other needs. We very much put an emphasis at that follow-up apartment on making sure the patient was aware of on call availability of the physicians and PAs in our practice and that somebody is available 24 hours a day to answer questions in any circumstance.

Once we have more of an internal process going, that is when we look to external actions. Go to the next slide. And the first thing we did here was to identify the primary hospitals that serve our patient population. And most of our patients go to first Memorial hospital, but we also have some that go to Duke regional, Duke UNC. And once we decided that [Indiscernible] would be our target hospital for follow-up process, we needed a contact person there to see if we could start getting communication going and those hospitals have a hospital liaison which First Memorial data entry at with hospital director and were able to sit down and identify the hospital processes and once we understood that to see how we could possibly integrate in pink sure that the hospitals were getting what they needed from us and we were getting communication from them as well.

In doing so, we found out that at First Memorial, a PCP was identified when the patient was admitted to the emergency room but sometimes that would break down if the patient was not conscious or could not give information or do not have family members. Sometimes the patient would be there but have no knowledge of a primary care provider and then also found out that the discharge summary temping was three weeks after discharge with how long the hospitalists had to get that discharge number done. If we were able to work together to get that reduced.

So the breakthroughs that we had, on the next slide. One was definitely the discharge summary. Again, that was one of the biggest frustrations from our providers in our practice, not having any information from the patient hospitalization. In with getting that discharge summary temping for the hospitalist reduced to 72 hours, that was probably one of the biggest things we were a will to accomplish. And then for us, establishing that internal protocol and involving the entire staff from the front office all the way to the floor coordinator in getting the patient taken care of and having something that everyone knew exactly why we were doing it and the importance of why we were doing it.

We definitely sought improvement. We did not have a huge population that we were dealing with but you can see our numbers from May 2012, we have 17% of our patients being seen within five days of discharge and that group had been satisfied at high risk. In later that one of two almost 70% in June. We were still having a little bit of a no-show issue. And then we dropped our medium follow-up time from nine days down to three days which we thought was fantastic. The discharge summary grew tremendously so we
were able to see only about 71% a year ago, and then typically 100% uptime is getting close discharge summaries and at the time that the patient was seen.

So, work to do. We obviously want to continue to collaborate with local hospitals and getting notification when our patients are admitted and discharged in finding out ways to make that an easier process. And then for us, understanding and getting that readmission data. So, we would sometimes only know if they were admitted when we saw them back and followed up again and being able to know kinder through the patients were that had those issues were. Beneficial to us. Right now, we were really only getting the Medicaid patient information, specifically from community care of North Carolina. I am hoping as we find ourselves [Indiscernible] models should help with that communication and readmission data. And internally working on it patient education and teach back fields, planning ahead for visits and just really encouraging the medical home model that we strive to have all the time.

Okay. So I mean, to me, that's just a fabulous example of, you know, the inpatient and outpatient side working together for the good of the patient and actually having that really smooth, warm handoff so that the patient does not miss a beat in their care. And so again, I want to thank you, Liz, for all of your work and the great example that you have served as in our project.

So to finish up, what I can tell you for sure is that if hospitals communicate the primary care practices, transitions follow-up for high risk patients, patients definitely improve and on the practice aside, practices embraced these handoff and work with these care concept, then not only do readmission rates go down, but patients do better. And so, we would challenge everyone on the call to get a hold of this change package & practices in your community that you can partner with in this same way and find out what parts of it worked for you and what parts don't. And we would love to get your feedback so we can make our packet even better. And we will make this available through the NCHA program and website and it will also be available on the and see AHEC and Community Care of North Carolina websites. And so with that, I will end the presentation and be happy to answer any questions and turn it back over to the quality Center hosts.

Thank you very much, Dr. Cykert, and Liz, thanks for sharing that and I definitely want to open it up and see if any of the participants on the call have a question or a comment that they would like to make. If you have called in over the phone you can raise your hand in we will un-mute your line. If not, you can type your question into the chat box and we will read it out.

We had one question, too already from a participant interested in getting some standardized follow-up phone call questions. So, is there content on that? I was wondering if in that change package, did you all have any standardized content or questions for that initial follow-up phone call?

No, we don't have a script for that. Those were created by the practices themselves.
And I can ping from the practice aside, that that might be something that would be a little more specific to each individual practice. Do any other hospitals that called in today have some standard phone call questions that you would be willing to share? Please just check in and let us know if you have a questions that you standardized and would be willing to share with the group, that would be helpful.

Well you all were doing that, I thought of the question as we were going through. We have been saying in the collaborative we want our folks to communicate with primary care practices to inform them that their patient has been hospitalized. But, would it not also be helpful if somewhere during that and informing the practice that we have assessed that patient at high risk of readmission? Would that be something helpful for the practices to hear?

Yes, definitely.

Great. That is what I was thinking from what you have said but that is a refinement, we have built in as an actual measure. Yes, informed them that they have been packed gushed hospitalized but all the more assessed them and let them know that they had been high risk for readmission. That may practice -- that might find that practice that they need a special level of attention.

Right. And I think two other things about that, Laura, is that number one, if indeed the patient is flagged at high risk, then the discharge summary at to be ready when the patient comes to the practice. Those ought to be priority discharge summaries, just like when you send someone to a nursing home. And I think the second issue here is, you need to tell the patient how important this is in their care, that they reestablish their care on the outpatient side as quickly as possible.

And just to jump in from the previous question about standardized questions for the hospital follow-up phone call, we did develop those and make a standardized question for each phone call that we make. So, the initial phone call as well as the phone call after that hospital follow-up visit. And it may be different from our site, obviously the hospital site. But we do have those.

Great. We also had a question country wondering if you could suggest any strategies to facilitate having a hospitalist participation in the call to the primary care practice at discharge.

Don't pay them unless they call.

[ Laughter ]

That would be motivating. That is one potential strategy. Have you seen some others that worked besides that?
No. I think that is a really interesting question. Because, I mean, the big problem is that hospitalist obviously are scooting around and if the practice initiates the call, then hospitalist is often hard to find with any immediacy. And then on the other hand, it works the other way. Many practices have phone [Indiscernible] that make it hard to get to the provider responsible for the patient and the hospitalist gets frustrated calling the practice. So, one thing that I would suggest is getting your primary care practices and hospitalist together. You know, give them a nice dinner. Maybe a little liquor. Liquor was a joke, okay?

[Laughter]

But anyway, get them together and have them brainstorm on how they could best contact each other. Maybe it would be an e-mail system. ABA text system. Something where -- may be a text system. Something where the immediacy can be recognized and that the information could consistently get across.

That was by far the most beneficial part of our interactions. Actually sitting down with Dr. [Indiscernible name], the hospitalist Director. and getting feedback from him and being able to give hours to him as well.

And you did that without liquor, right?

Sometimes, yes. I think there may have been line involved.

[Laughter] --

I think there may have been line involved.

[Laughter]

Anything that facilitates the flow of communication.

A couple of things that makes me think of. One of the questions that I am going to pose for our hospital representative attendees on the call. That is, what can you do to speed up that discharge summary for high risk patients? If anybody has a way that you are already doing that or the King of, get the -- or that you are enough, get the discharge summaries to the high risk leases more quickly. Chatting and let us know how you are thinking about doing that.

My question to our presenters, while they are getting a chance to type that in, if the practice does not initiate a conversation with the hospital, you halted because of your project, the practice would contact the hospital informed those conversations. What would it be like if the hospital contacted the practice? Are there any particular tips for us about how to go about doing that as our hospital teams are reaching out to the
community and making connections? We would want them to contact their practices. Any tips on how to do that most effectively?

I would say just setting up a time to sit down in a face to face type of meeting. I think that would be well-received by any practice. I can't imagine a practice saying no to that request. Pull --

It would probably be fairly well received, you think, if you were to make that connection and say we would like to talk to you about better transitions for our hospitals and patients at high risk for coming back into the hospital.

Sure.

I think I would emphasize the idea. Two things. Number one is that a lot of certain, and not so much the high risk of readmission, but also the high risk of deterioration that is of certain. You know, especially given that recent mortality data, because obviously, people really care about these patients. And then, I think a second thing to talk about would be the utilization of the Medicare transition codes. So that practices understand that this just isn't a hospital financial issue, it can benefit the practice, two.

Correct. And those can be successfully done. There are definitely a lot of steps involved in those transition codes, but we have been utilizing them since April and they can be done.

Are there any suggestions or guidelines in your change package about how to best utilize those codes and help your practices do that? And if not, do have any tips?

[Indiscernible] a package that talks about the billing aspects but that is a good idea and something that we should look at putting in.

So some of our folks are typing in their responses to how to speed up that discharge summary. And one of our hospitals-automated process already in place that automatically flows the discharge summary once it is completed. I would ask, though, to flag it as high risk and also others are saying that there hospitalist this -- dictate the same day as discharge and auto fax it the same day as it is transcribed. They don't wait for the hospitalist to approve it, they fax it first.

Yeah, that is perfect.

So those are some ideas for those that are struggling with this and not doing it quite that way might want to consider implementing some of these approaches. We have only had those to come in. Any others? If you have a suggestion or idea or something you're working on to get that discharge summary turned around more quickly for the high risk patients, go ahead and typed that in as you can. And are there any other questions or
comments for our presenters? I see somebody is typing into the chat or raising their hands to talk. But I am not seeing anyone else do so.

All right, well, Laura, I have just been called that I have one of my hospital follow-up patients to see.

All right.

So I am going to go ahead and break a way to do that but I would be happy to answer any further questions through e-mail at a later time. And thank you again for allowing me to participate today.

Thank you very much for presenting. We really appreciate that information and we will need to be in touch with you.

All right, very good.

Okay, thank you. For those still on the line, our participants, particularly for those that are fully in the collaborative for the rest of this year, I wanted to do a quick review on the process measures and how to enter them. Just because we had a few glitches with it that very first of data entry. And I just wanted to make sure that you are aware of how to do that.

The new process measures in place of the patient is given an assessment for high risk of readmission. First you have to do that in order to get the basis for the other two measures. And that is of those high-risk patients. Unless the primary care physician informs of 48 hours and of that same group, was a follow-up visit settled within seven days?

This next slide shows you what the data entry looks like and some of you are very familiar with this. You have entered your data. Most of you have, some may not have, yet. As you can see it is a very simple process. Not a lot of entry and not really complicated. The complication to this is if you are not yet assessing risk of readmission and many of you are not yet, what you would have done for July, let's say you had the patience in the pilot unit in July, if you had assessed 90 of them, that is the way that you would fill that in. That in August if you had 102 patients in the unit and you assessed 97 of those, you would fill that in at that point.

As you can see, the other two process measures are based on of that group that was assessed at high risk, that becomes your denominator. In July, at about 100 patients that you assessed 90 of them, 20 of them were found high-risk Thomas. becomes -- high risk, that becomes the denominator and out of that group, how many were informed, within 48 hours, how many of those have their follow-up visit scheduled within seven days. That is how it works with switching the denominator from the first measure, everybody in the unit. Say everybody was assessing high risk. The next slide shows a
little bit more of what it looks like if you had not started assessing risk at readmission, yet. If you don't have your risk assessment in place yet, you're delighted it would have been out of 100 patients in your unit. You have not assessed anybody yet in July. Therefore, you have not identified anybody high risk, yet. So the other two measures are going to be zero and zero.

The first measure is not zero out of zero, it's zero out of however many patients. And you might continue with however many zeros through August and maybe even September although I would hope starting this month you might be testing. And you might very well have out of that 100 patients on the unit or 101, even if you only assessed for as a way of testing your assessment tool. That is the type of progress we would hope to see with these measures. So that is sort of what it looks like.

Your next round of process measures are due on September 20 but if you have any questions about them as you go along, please get in touch with any of us have the quality center and we will help you out. If you realize now that we have talked about it again that he entered your August data wrong, you can go back and fix it. It's not a problem at all to go into the prior month and correct any errors in your data. You can certainly do that.

We are now going into the monthly webinars for the full collaborative group. At education track, you'll be having quarterly webinars and we will send notifications about those. Our next webinar will be on October 14. We will be having hospitals share about overcoming barriers and sharing. Some of our hospitals have struggled to get traction going with projects. We will talk about what has worked in what strategies they have used to keep things moving forward. At this point I want to ask if there are any concerns relative to data submission or relative to your work with risk assessments. I have the -- I know many that I have talked to are actively working with those risk assessments. Does anybody have a question that they want to post to the whole group about those topics? Any question about your risk assessment or process measures?

While you are having an opportunity to do that, I also want to mention that the change package that Dr. Cykert referenced will be posted on the collaborative website very shortly. So you will be able to go in and access that. It's very thorough and very large and has great resources and ideas in it. It will be very worth your being able to pull it down and have a look at it. We will have it posted for you very soon. Any other questions or comments?

I am not showing any, Laura.

Okay, I am not seeing any come through. So at this point, I will say if you have further questions or comments after the webinar, feel free to get in touch with us. You can always call me or send an e-mail and get in touch with Dean or anyone of us here at the quality center. We would be happy to respond to any questions you have. I want to thank you for your participation in today's webinar. You'll be receiving a few evaluation questions after the webinar and we encourage you to please fill those out and let us know. That helps us plan future webinars that better meet your needs.
Thanks. I want to add to the announcements we have been sending out weekly e-mail updates about upcoming events. There are a few, kind of, extra webinars that we have been promoting outside of the collaborative but very relevant. I want to encourage you to take note of those and share this with your colleagues. The last one I promoted today was being shared by our colleagues in Virginia. It is on HCAHPS and the connection with readmission rates. That should be a great connection and I encourage you to join in if you can next Wednesday. That information will be sent out via e-mail.

In closing, I would like to again thank Liz Riley and Dr. Sam Cykert for their wonderful presentations and sharing today. And again, if there are no questions we will close out our session. Thanks a lot, everyone.