



CLINICAL SAFETY & EFFECTIVENESS COHORT # 15

Improving Patient Attendance for Transitions of Care Clinic



CENTER FOR PATIENT SAFETY & HEALTH POLICY

UT HEALTH SCIENCE CENTER™

SAN ANTONIO

Educating for Quality Improvement & Patient Safety

THE TEAM

○ Division

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○ Sponsor Department:

- **Dr. Jean Carlos –Chair of Department of Family & Community Medicine**
- **Division of Geriatrics**
- **Primary Care Center**
- **UT Senior Health Clinic**

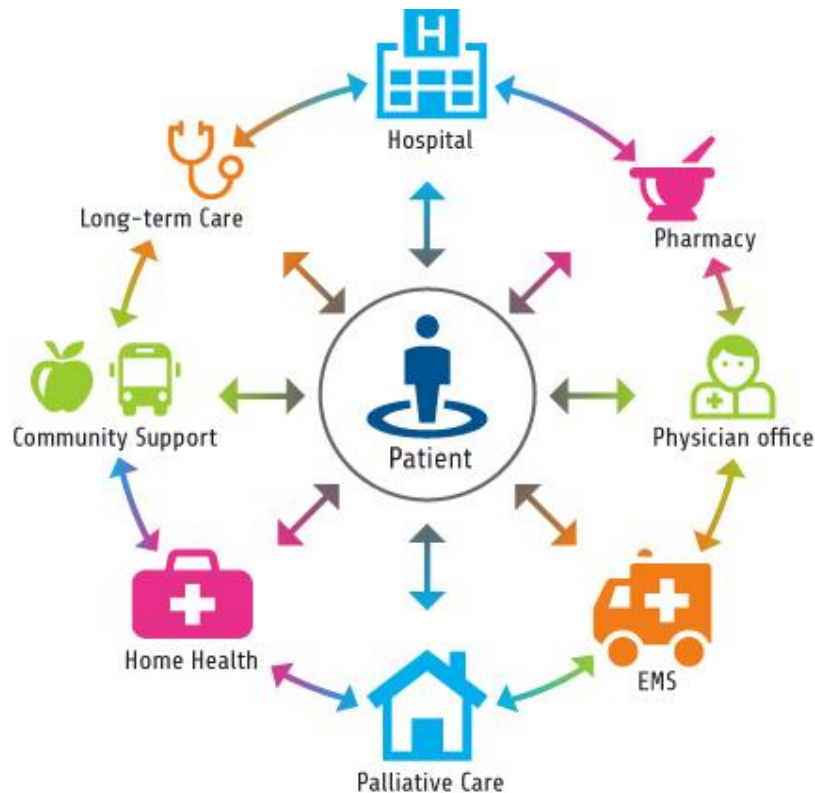
AIM STATEMENT

- To improve patient attendance for the Transition of Care clinic at the Senior Health Clinic from 50% by 20% by January 2015.

PROJECT MILESTONES

- Team Created 9/2014
- AIM statement created 9/2014
- Weekly Team Meetings 09/19/201,9/26/2014
- Background Data, Brainstorm Sessions 09/19/2014
9/26/2014
10/10/2014
10/29/2014
- Workflow and Fishbone Analyses 10/6/2014
- Interventions Implemented 11/10/2014
- Data Analysis 11/12/2014
11/17/2014
- CS&E Presentation- Preliminary 11/21/2014
- Graduation Date 01/23/2015

BACKGROUND

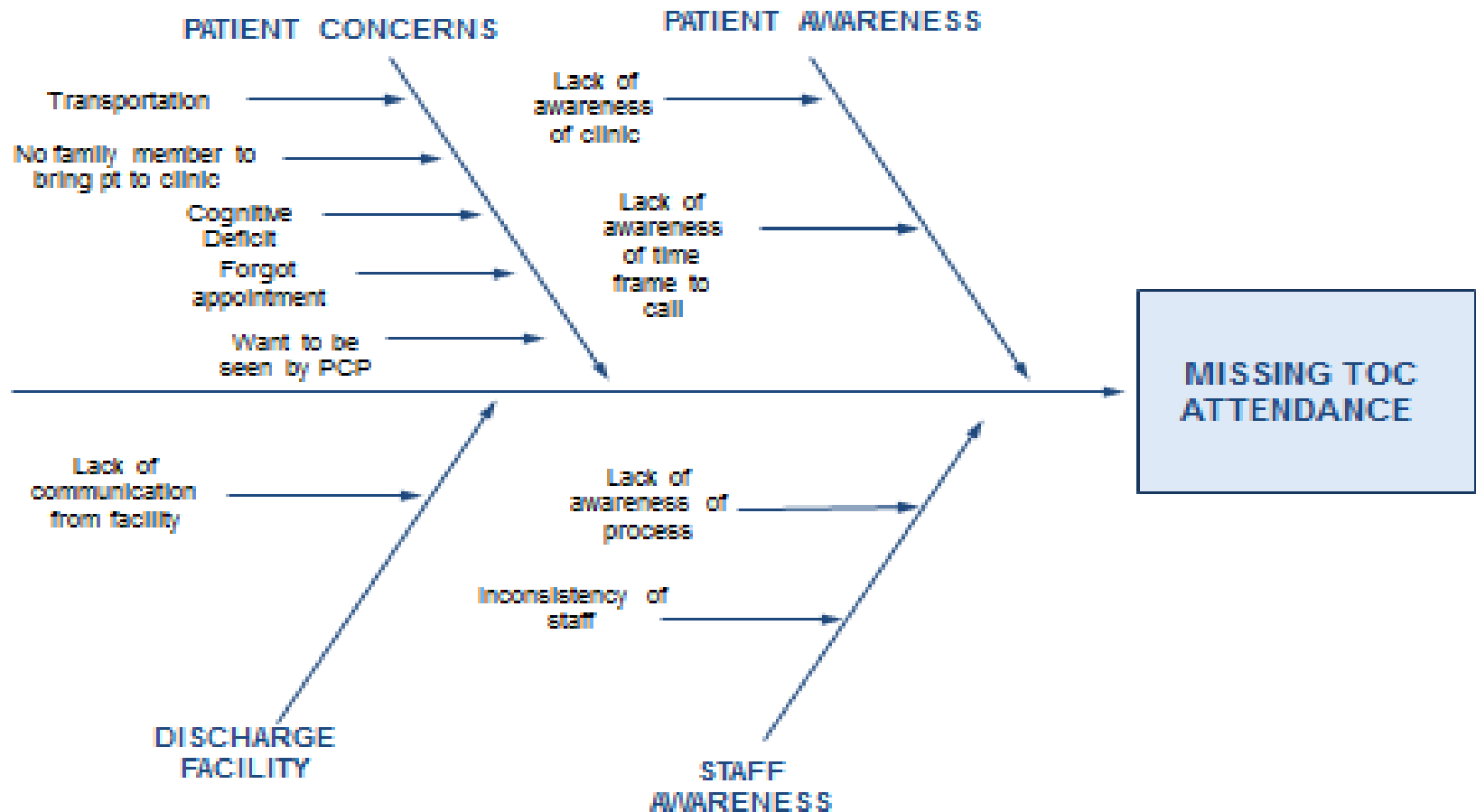


- The TOC clinic is a new service that started at the Senior Health Clinic in November, 2013
- The goal of this project is to improve the hospital discharge follow-up of patients at the Senior health clinic.
- Literature says it is imperative to see patients in transition to address the handoff from the hospital to outpatient setting
 - s/p Medical crisis
 - Change in therapy
 - New diagnosis
 - Need of specialist
 - The risk of medical error and readmission is high as 16%

Family Practice Management 2013 May-June;20(3):12-17



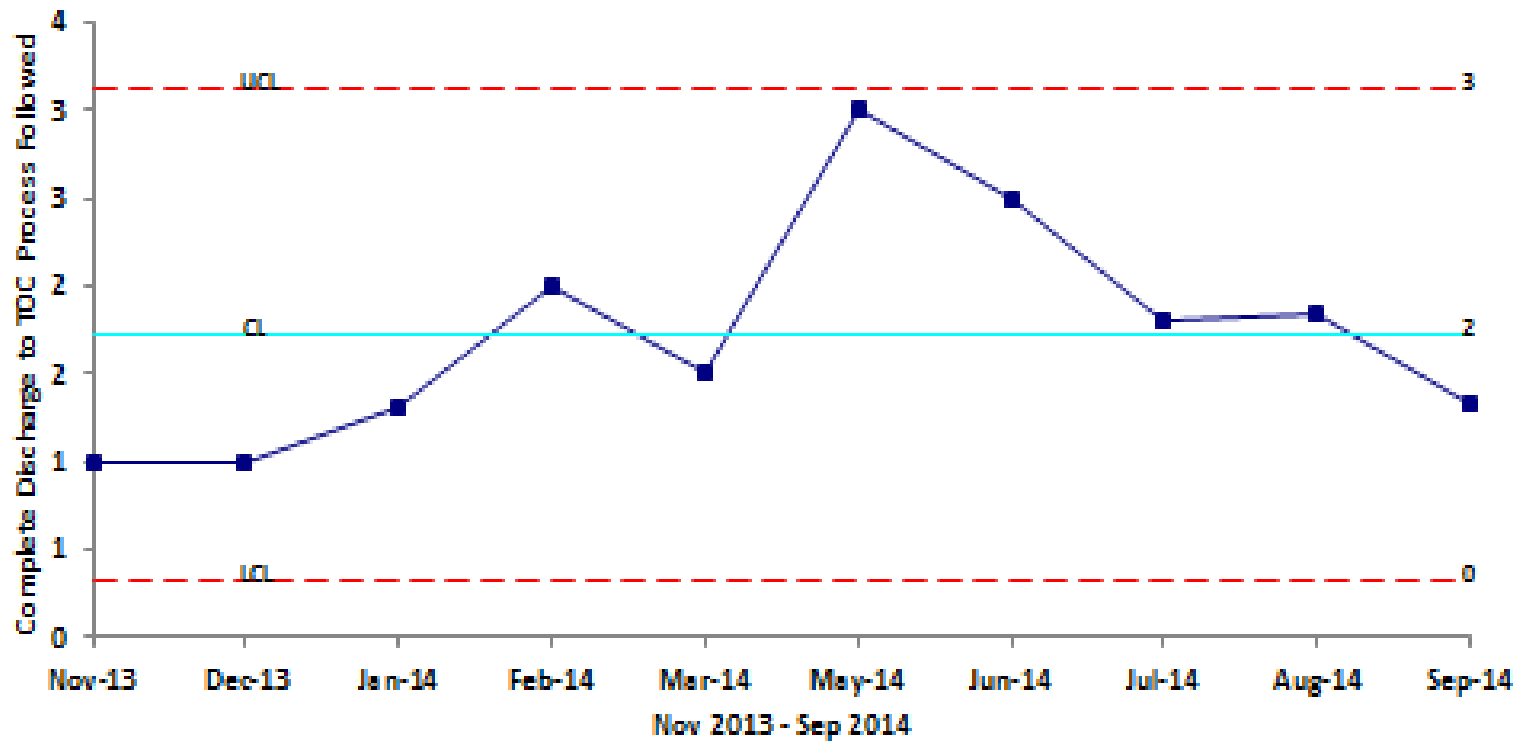
PROCESS ANALYSIS TOOLS



Three Step Process –Pre Intervention Data

1. message entered in epic about the patient discharge
2. TOC call made by clinic staff
3. Patient came for the appointment

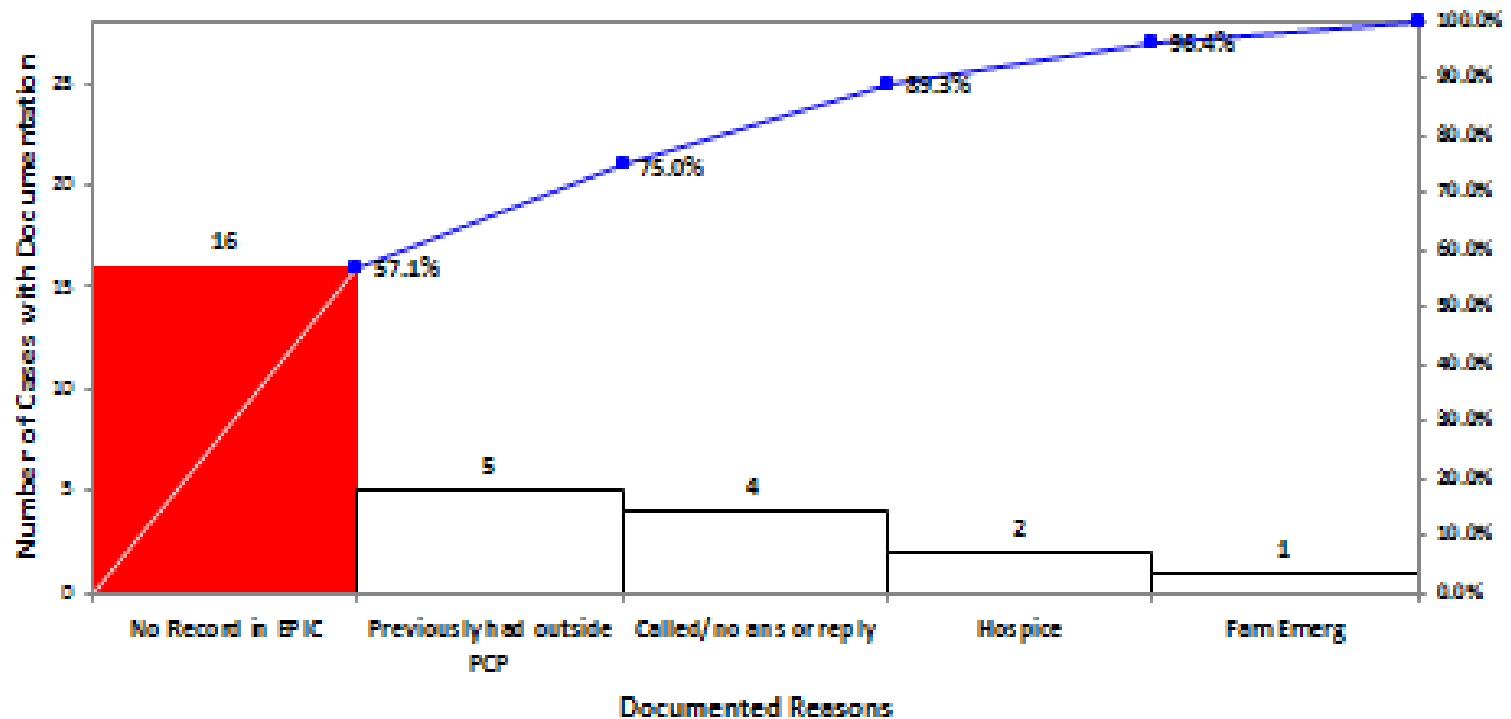
ACE Unit Transitions of Care Clinic
TOC 3 Step Process Followed



Pareto Chart

Reasons for cancellation

TOC Cancellation/No Show Rate and Reason



OUR FOCUS

○ Patient Awareness

- Educate our patients about the TOC service
- Patients are informed that if they are ever in a hospital or Rehab/SNF to call on the day of discharge.

○ Staff Awareness

- TOC visits: 24-48 hours after discharge, we have to have a Telephone encounter charted in EPIC.
- Within 7-14 days, patient will be seen for a follow up discharge visit.



PLAN: INTERVENTION

Our focus is to increase patient and staff awareness of TOC clinic.

○ Improve patient awareness

- Visible sign about TOC in the patient waiting area in the senior health clinic.
- Mass email to all patients about the TOC clinic.
- Visible signs in the patient rooms in the clinic.
- Colorful Handout for all UT senior health patients who are being discharged from the ACE unit.
- Colorful Handout for all patients who come to the clinic.

○ Improve Staff awareness

- Consistent staff personnel to address the TOC visits.
- Establish a process from ACE to Home and Rehab.
- During the week days, the ACE Unit Nurse practitioner will send EPIC message about patient discharge.
- ACE residents will send EPIC message about patient discharge

PLAN:INTERVENTION

I. Discharge process

a. To Home –

- i. The ACE NP will a message in EPIC to the TOC nurse at the Senior Health Clinic notifying her of patient discharge .
- ii. TOC Nurse will make a TOC appointment and complete a **.PCTOC TELE** encounter.
- iii. If family calls the clinic for a TOC appointment, the call will be transferred to the TOC nurse and the TOC nurse will complete the **.PCTOC TELE** and schedule the appointment
- iv. If the nurse is busy with some other duty, the MA that takes the call and will enter a **.PCTOC TELE** encounter and forward it to the TOC nurse and the TOC nurse will get back to the patient.

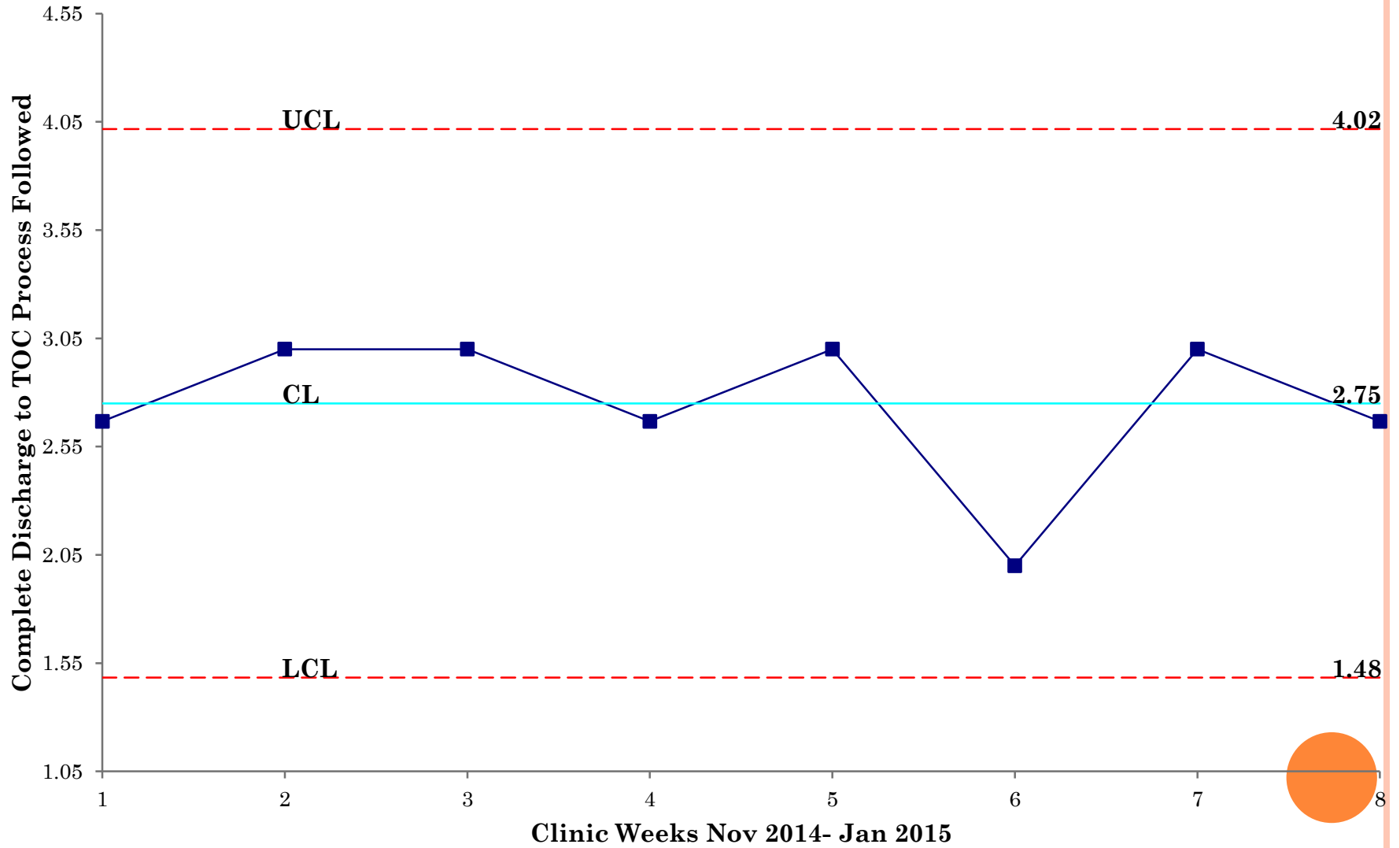
b. To SNF/Rehab UT (next phase)

- a. The nurse practitioner will send a message through EPIC to notify the TOC nurse of patient discharge from the hospital and the TOC nurse will track the discharge date from SNF/Rehab and arrange appropriate TOC visit.

IMPLEMENTING THE CHANGE

- Start date: 11/19/2014.
- TOC Handouts given with the AVS at clinic visits.
- TOC Handouts given with the discharge summary at the ACE unit
- Visible sign for the TOC at the ACE unit and Senior Health Clinic.
- TOC nurse to do all the TOC telephone encounter and the TOC clinic.
- Staff will ask patients if they were in the hospital when they call for appointments.
- Resident will send the message encounters for discharged patients during the weekend.

Ace Unit Transitions of Care Clinic TOC 3 Step Process Followed Post Intervention



ACT: SUSTAINING THE RESULTS

- Continue the 3 step TOC process on a system based approach.
- Educate all staff of Senior Health clinic on how to enter a .PCTOC TELE telephone message encounter.
- Create a TOC pool to send messages of patient discharge from hospital/SNF/Rehab.
- Continue to have a designated nurse to respond to TOC messages and make TOC appointments.
- Have a select number of staff and providers function as back up responsible for responding to TOC messages.

RETURN ON INVESTMENT

Increased TOC visit

Patient gain

- Decreased hospital readmission
- Increased Patient satisfaction
- Increased patient admission to the CSR hospital(ACE unit) as opposed to other hospitals; therefore continuity of care
- Increased number of new patients to the clinic

TOC visit- \$200- 300 difference compared to the regular office visit.

2 Month financial gain –approximately \$10,000-15,000

CONCLUSION/WHAT'S NEXT

- Anticipate increase in patient satisfaction with continuation of care.
- Increase in new hospital admission to the ACE unit.
- Decrease in re-admission rates.
- Increase in consults from Rehab and SNF facilities.
- Increase in revenue for the clinic.

Thank you!



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