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Title: CREATING A TRANSITION OF CARE PROCESS FOR VETERANS ADMITTED AT OUTSIDE HOSPITALS

Abstract:

I.) Statement of Problem: Veterans who receive their primary care at the VA are at increased risk for adverse outcomes when hospitalized at non-VA facilities because there is no system currently for communicating about the hospitalization to provide a safe transition of care. When patients leave these hospitals, follow up imaging may be needed, specialty consults may need to be coordinated, and early follow-up with a primary care provider, which has been shown to improve post-discharge outcomes1, may need to be arranged. Additionally, important high-risk medications (eg clopidogrel after coronary stenting, antibiotics after infection) prescribed at hospital discharge cannot be filled by most patients until they have a face-to-face visit with a VA physician who can then prescribe it. Currently, there is no standardized system by which this occurs at the Denver VA (or at any VA hospital in the country we are aware of). Thus, the burden of making and completing follow-up appointments and transferring important hospitalization information largely falls on the Veterans themselves.

In this pilot inter-facility quality improvement intervention, we propose to improve transitions of care for Veterans hospitalized at Rose Hospital (where we have co-investigators and significant buy-in) through implementing a universal process and checklist for Rose case managers and VA providers to follow. To our knowledge, this is the first joint VA-community hospital project undertaken to create and analyze a transitions of care intervention between these two types of facilities using QI methodology.

We began with a study of the existing process and learned it had multiple failure points. Records were typically not sent. When they were, or when they were requested, they were usually sent to the medical records department instead of to the PCP, where records were slowly scanned in. However, if the PCP’s name was not present on the records, they were shredded. We learned that each of the Firms where PCPs reside at the VA have a fax, but not all providers knew where they were or checked them regularly, and their numbers were not known to outside providers. Patients had difficulty arranging a post-hospital follow-up when they called, and there was no way in the VA’s EMR to label a visit as a post-hospital follow-up, so the providers at the VA could not anticipate and obtain records before the visit.

We then studied other community hospitals and clinics that communicate successfully and adapted previously successful interventions to the unique context of the VA and Rose Medical Center. We believe such a process will significantly increase Veteran follow up rates and receipt of pertinent TOC documents in time for a follow-up visit.

We began the intervention on February 1st and have since completed several PDSA cycles to enhance the intervention. We began collecting initial data on outcomes on July 1st.

II.) Innovation Objectives: Now that we have completed PDSA cycles to make the intervention reliable, feasible, and acceptable to stakeholders, we are examining two main objectives. For our primary objective, we aim to double the rate of completed Veteran post-discharge VA follow-up from approximately 30% to approximately 60%. A Veteran post-discharge follow-up visit is considered
completed when the Veteran is scheduled and attends a follow up appointment with the Veteran's PCP or an Outpatient Based Medical Team visit (resident staffed, short notice appointment clinic) within the designated recommended time period as designated by the Rose Hospitalist on the TOC Checklist.

Our secondary outcome aim is to increase the rate of timely receipt of discharge documentation from Rose providers to VA providers. We define this as records received prior to the patient's appointment and available for review by the physician who will see the patient. As of now, our estimation is this happens <15% of the time. Our first goal will be to demonstrate a tripling of this compared to previous 6 months. Per Rose Case Manager estimation, 10-12 Veterans are hospitalized at Rose per month; to demonstrate an increase in our primary outcome of 30% to 60% follow-up (40% to 80%) we need 42 patients in each group (pre and post). We have identified the pre-intervention cohort and are starting to collect data on the post-intervention cohort now. Eligible Veterans are those hospitalized at Rose on a Medical/Surgical floor during our time period of interest; we will compare outcomes for 12 months pre-intervention and 6 months post-intervention. Ineligible Veterans are those who have PCPs outside the main Denver VA Firms (Aurora, Golden, Private, etc.), those who are only seen in the Rose ED and not hospitalized, those whose Primary Care is received through the Geriatric Service, Veterans discharged to skilled nursing or long term care facilities after Rose admission, Veterans who expire at Rose Medical Center and Veterans transferred to another facility prior to discharge at RMC.

III.) Program Description: We have developed and implemented a system for Rose and VA providers. The first step in our program involved gathering the fax numbers for the different Firms/Clinics at the VA and ensuring they worked. We also needed to ensure they were monitored and were the correct fax machines to use. For example, in one Firm the listed fax machine was in a closet and was infrequently checked.

The second step created a checklist/form and flow sheet created for Rose case managers. Case managers at Rose initiate discharge planning on day one of hospitalization through this checklist. It covered important topics such as patient information, a nursing section (assistive devices needed, vaccinations given), a physician section (diagnosis, outstanding results, high-risk medications needing approval) and a Case management section (durable medical equipment, physical and occupational therapy, home health, substance abuse). All of this information is collected on one page and faxed over as a cover sheet for discharge documentations. There is a second page for the case managers to check off important parts they have collected for the transitions of care documents package and the fax numbers of all clinics.

The third step involved creating a flow sheet for making a follow up appointment for a Veteran based on the Veteran's status (location of PCP, no PCP, appointment time needed and when available appointment is needed) and where to fax transitions of care documents. One thing we adjusted in PDSA cycles in this step is where the case managers call to make an appointment. In order to get the correct PCP information for the Veteran and in order to track Veterans for our primary and secondary outcomes, it was determined after exploring several options that they should call a particular extension of the VA appointment line. Steps 2 and 3 were implemented by meeting with Rose case managers to discuss the above checklist and flow sheet, getting their input and recommendations on alterations and creating a finalized joint version. Dr. Austin, a hospitalist at Rose was involved in promoting this to other hospitalists and having discharge summaries complete the same day.
The fourth step came after another PDSA cycle, in which we realized that the VA firms had no system in place to receive the transition of care documents. Medical assistants and nursing staff did not know what to do with the documents once they came over. We met with the entire staff of each Firm several times to discuss what they were doing, getting their input on what Rose management was collecting and planning a system to receive the information. The Rose case manager transition of care form was subsequently altered to take in their requests. A flow sheet was then created for the medical assistant and nursing staff to receive, process and deliver the transitions of care documents to the proper physician based on the Veteran's follow up appointment. A nurse from each Firm volunteered to be a champion to promote this system and educate the Firm staff about it.

A subsequent PDSA cycle showed another alteration that needed to take place. Receipt and review of the documents largely depended on the presence of staff attendings who are there 5 days a week to receive and review the documents. However, one of the Firms is a resident-only clinic overseen by attendings in other Firms and is located in a different physical location. The PCPs are residents who are only there every 5 weeks. A separate system needed to be created for this Firm. An additional PDSA cycle involved developing a way to track Veteran data. After meeting with the nurse champions for each Firm, it was decided that a standard practice would be created were the nurse who was processing the documents would write a note in the VA's EMR stating that a follow up appointment had been scheduled for the patient and that the documents had been received. A final PDSA cycle involved monitoring the system and educating participants in the system from Rose case managers to VA appointment line nurses.

IV.) Findings to Date: We are currently collecting quantitative data, but in qualitative analysis we have found, the case managers at Rose have adopted the checklist, form and flow sheet with resounding enthusiasm as it streamlines their job in a non-burdensome way and gives them a structured plan of completing their jobs. On the VA's side, the VA Firms have greatly appreciated having Veterans scheduled for follow up for them and having the ability of getting important notification prior to the Veteran's discharge and documents (especially discharge summaries) prior to the Veteran's appointment. There is minimal effort exerted on the VA's side as there are on average 12 Veterans a month spread over 3 Firms and the nursing staff have appreciated greater insight and involvement in the care of their Veterans. After the initial PDSA cycles described above, there have been few problems noted on either end and the system has overall been running smoothly.

V.) Key Lessons Learned: Initial and subsequent investigation into the Rose and VA systems underlined how fragmented our system is. It also illuminated how difficult setting up a solution to the system, or any QI, can be given the inherent complexities and deficiencies in the system and the number of players involved. This project was done as simply as possible, given the above, in that it involved only one hospital and a few clinics that were both geographically close. Even with that, there were multiple hurdles to circumvent in developing this process. Another lesson learned was the difficulty in tracking non-numerical objective data between two systems that are not linked. On the positive side, we learned that providers in both facilities, and likely everywhere, are hungry for a solution to the fragmentation and eager to invest themselves in one that looks promising. If there are promising results from the quality improvement innovation, there is then potential to expand this to other hospitals and VA facilities.