CUSOM Maintenance of Certification Part IV Credit Quality Improvement Project:
MOC Part IV Project Pre-Review Form

We strongly recommend that the project lead(s) complete the MOC Part IV Project Pre-Review Form. This form is intended to describe a project that is in the development stages; some questions may not apply. If the project has already been completed and is eligible for MOC Part IV credit review, this form is not necessary. Pre-review for projects is typically provided within 1-2 weeks after submission.

Only one MOC Part IV Project Pre-Review form per project is necessary, despite the number of participating physicians. While pre-review is not mandatory, it provides the project team with guidance for assuring that their approach to the QI project is consistent with CUSOM requirements for granting credit. Please see the MOC Part IV Project Approval Criteria for a complete listing of project requirements. Questions and/or completed forms should be sent to the CUSOM MOC Program manager.

Date: November, 2012

Title of QI Project:

| Improving Timeliness of Discharge Communication at University of Colorado Hospital (UCH) |

I. PROJECT PERSONNEL

A. QI Project Lead(s):

| Name and Title: | M. Douglas Jones, MD |
| Department/Specialty: | Pediatrics/Neonatology |
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| Email: | Doug.jones@ucdenver.edu |

Name and Title:  
Department/Specialty:  
Address:  
Phone:  
Email:  

CUSOM MOC Part IV Pre-Review Form.V3.1.2.14
II. PROJECT DESCRIPTION

A. Stage of Project:

- [ ] Design in progress
- [ ] Design is complete, but not yet initiated
- [x] Initiated and now underway
- [ ] Other, please explain:

B. Funding Resources: [Check all that apply]

- [x] Internal sources, please list:
  - ACT 1 (UPI, UCH, and CUSOM)

- [ ] External sources (i.e. grant, national funding), please list:

- [ ] Other, please explain (if no funding, select this option):

*NOTE: COMMERCIAL FUNDING SOURCES ARE NOT ACCEPTABLE FOR CUSOM MOC PART IV CREDIT PROJECTS*

C. What is the identified problem in quality that resulted in the development of this project?

Poor discharge communication can jeopardize safe transitions from acute care to community based primary care. While it is required to complete a discharge summary to convey information about a hospitalization, it serves no useful purpose if it does not get into the hands of the primary care provider in a timely fashion.

D. What is the project aim(s) regarding the problem in quality?

At UCH the rates of timely discharge summary completion were quite low. The aim was to roll out an integrated electronic medical record providing opportunities to improve processes associated with discharge summary completion.

E. Is the project associated with any larger UCH or CHCO initiatives or national initiatives?

- [ ] No
- [x] Yes, please explain:

ACT 1, a collaborative effort of the UC SOM, UCH, and UPI identified transitions and communication with outside providers as important priorities. Discharge communication was identified as the first target of performance improvement efforts. Reducing fragmentation by improving transitions of care has become a focus of policymakers. In particular, CMS is rolling out all cause 30-day readmissions as a quality measure that is linked to reimbursement.
F. What patient population does this project address? What is the approximate sample size?

All hospitalized patients at University of Colorado Hospital.

G. Which Institute of Medicine Quality Dimensions is addressed? [Check all that apply.]

- ☑ Safety
- ☑ Equity
- ☑ Timeliness
- ☑ Effectiveness
- ☑ Efficiency
- ☑ Patient-Centeredness

III. PROJECT MEASURES AND DATA

A. Measures of Performance:

1. What quality measures were used (e.g., outcome, process, and/or balancing measures)? If rate or %, what are the numerator and denominator (e.g., # of patients vaccinated / # of patients eligible for vaccine)?  See MOC Part IV Project Approval Criteria (item 7) for a description of quality measures.

<table>
<thead>
<tr>
<th>Measure: Proportion of discharge summaries routed to primary care provider (if one was available) within 72 hours of discharge from UCH.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator: The number of inpatients (having a primary care provider) whose summary was routed in EPIC to the primary care provider within 72 hours of discharge.</td>
</tr>
<tr>
<td>Denominator: Number of inpatients having primary care provider.</td>
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</tbody>
</table>

2. What are the sources of baseline data for the measures (e.g., medical records, billings, patient surveys)? What methods were used to collect the data (e.g., abstraction, data analysis)?

   1. EPIC EMR time stamps of DC summary routing
   2. Master list of Primary Care Providers (SER)
   3. Report was prepared by ACT 1 and EPIC analysts

3. How are data to be analyzed over time (e.g., simple comparison of means, statistical tests)?

   Run chart

B. Performance Objectives:

1. What is the overall performance level(s) at baseline? These may be displayed in a data table, bar graph, run chart, or other method; may show here or refer to attachment.

   The overall performance at baseline is 20%.
2. What are the targets for performance and the timeframe for achieving the targets? How were the performance targets determined (e.g. regional or national benchmarks)?

The performance target is 90% of discharge summaries routed within 72 hours of discharge among patients with a primary care provider. The School of Medicine Clinical Leadership Council suggested this benchmark and gained the approval of the UCH Medical Staff.

C. Identification of Primary Underlying Cause(s):

1. What is/are the primary underlying cause(s) for the problem(s) that the project can address? Causes may be communications or behaviors of people, processes, information infrastructure, equipment, environment, etc. List each primary cause separately. These may be shown here or refer to attachment.

<table>
<thead>
<tr>
<th>Cause</th>
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<tbody>
<tr>
<td>1. D/C summary not completed by resident in timely fashion.</td>
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<tr>
<td>2. D/C summary not signed by attending in timely fashion.</td>
</tr>
<tr>
<td>3. D/C summary not routed (auto-faxed) to primary care provider by physicians.</td>
</tr>
<tr>
<td>4. Primary care physician not recorded in chart or bad contact information.</td>
</tr>
<tr>
<td>5. Lack of accountability or ownership by staff and physicians.</td>
</tr>
<tr>
<td>6. Medical staff office policy sets a low bar of completion of record (including d/c summary) within 21 days.</td>
</tr>
<tr>
<td>7. Physicians using different means of communication to outside providers -- letters, calls, op notes.</td>
</tr>
</tbody>
</table>

D. Plan for Intervention:

1. Describe the intervention(s) to be implemented as part of the project. Show how the intervention(s) addresses each primary underlying cause.

<table>
<thead>
<tr>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assigning the work of identifying the PCP to unit clerks/registrars- this is tracked and these staff are held accountable for this metric.</td>
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<tr>
<td>2. Redesign standard d/c summary template with attending phone number--piloted by hospitalist group -- each physician/group will provide a contact number to be placed on the summary.</td>
</tr>
<tr>
<td>3. Will create reports that allow tracking at the department/division/individual physician level - monthly reports starting-- extensive process of developing final metric and format of report with EPIC analyst and process improvement staff with input from CLC members.</td>
</tr>
<tr>
<td>4. Pilot of auto-routing with Hospital Medicine Group-- EPIC feature to automatically fax d/c summary to PCP and 1 other provider loaded in EPIC.</td>
</tr>
</tbody>
</table>

We will create future improvement cycles based on the outcomes of the above mentioned.