EMR Guide: Accuro
Home to Hospital to Home Transitions

Contents

Introduction

This electronic medical record (EMR) guide will provide recommendations about how to utilize the Telus Accuro EMR in primary care clinic settings to optimize processes for paneled patients transitioning from home to hospital and home again. It is a companion guide to the H2H2H Transitions Change Package. EMR specific guides for AVA, Microquest Healthquest, Telus Med Access, Telus PS Suite are also available on the ACTT website.

Foundational EMR Guides

Before starting on the H2H2H Transitions Change Package, it is suggested that clinic teams have completed foundational improvement work in other areas of Patient's Medical Home. These recommendations can be found in the H2H2H Transitions Change Package Summary. The Guiding Principles to Effective Use of EMR for Patient's Medical Home Work provides guidance on several foundational topics such as:

- panel identification and management
- searches
- problem lists
- care planning
- measurement

Additional EMR guides for Accuro in other improvement focus areas are also available.

Guide Format

This guide provides EMR guidance for Potentially Better Practices (PBP) and Process Measures found in the H2H2H Transitions Change Package. They are provided in the order presented in the H2H2H Transitions Change Package, which may not reflect the order in which a clinic team may undertake the improvements.

Potentially Better Practices

Quality improvement (QI) is a systematic approach to monitoring practice efforts, reviewing and reflecting on the current state and looking for opportunities to improve. Measurement can be a way to monitor clinic operations and improvement. Each PBP has a list of proposed process measures that measures whether an activity has been accomplished. Process Measures are often used to determine if a PDSA cycle was carried out as planned. The following are recommendations to implement within your EMR.

EMR Advice to Potentially Better Practices

The following are organized by Potentially Better Practices (PBP) and their Process Measures outlined in the H2H2H Transitions Change Package Summary where EMR may be of assistance. For more rationale on the PBP refer to the *Evidence Summary*. For an additional list of measures and examples, refer to the *Measurement Guide*.

Taking the time to establish these EMR practices will build transferable skills and capacity. Additional information about the technical enabler can be found on the CII/CPAR web page.

Figure 1. H2H2H Transitions Change Package Summary

Standardized Text

Wherever possible teams should use standardized text. This may take include multi select observations like dropdown lists or, macros which specify standardized text that can be dropped into free text fields. For more information about how to use observations or macros in Accuro, see the online help files.
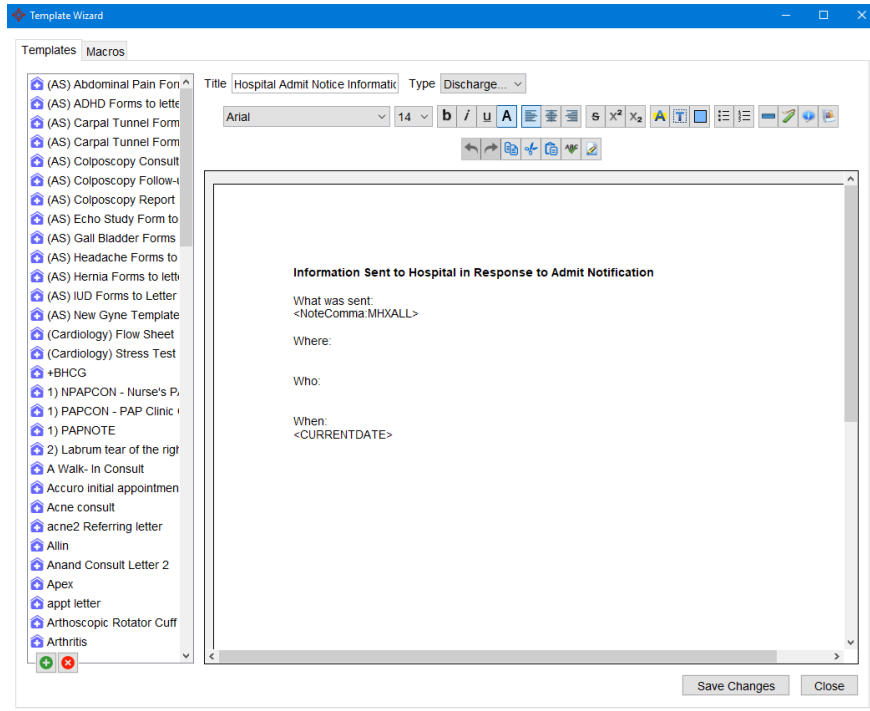
Potentially Better Practice 2.1: Upon receipt of admit notification, develop a process to provide hospital team with any relevant patient information

If information is shared with the hospital team, ensure that it is recorded in the EMR. This includes who, when, what was shared and outcome of the call. Use searchable terms. You should have a discussion in advance with your physician and team about what information is appropriate to send to the hospital without patient consent.

A common way to do this in Accuro is to record the exchange of information in a **Note** in the patient's chart. You may wish to use a note template to standardize data collection. Here is an example of the template's potential content:

Process Measure 2.2: Process exists for identifying patients discharged

Process measure 2.2 is a proposed process measure for PBP 2.2. When a clinic receives information that a patient has had a visit to an emergency department or a hospital discharge, the clinic is to have a process to understand the procedures to identify when patients are discharged.

Use the **Medical History** band to capture information about a patient's hospital discharge. The **Surgical/Medical History** band could be a potential location for adding this information. Data in the Medical History band can be queried routinely.
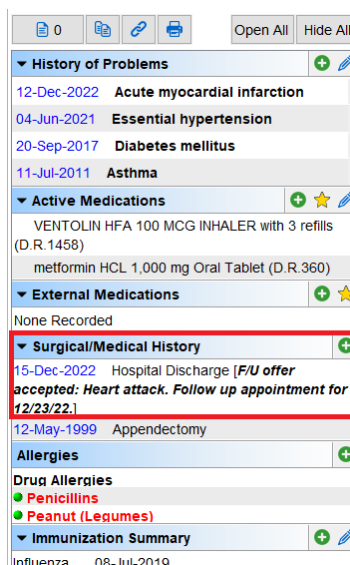
Potentially Better Practice 3.3: If a risk of readmission score has not been provided by acute care, develop a process to determine who your high risk of patients are

Utilize Accuro's **custom lab test/result** feature to capture LACE Readmission Index for patients discharged from the hospital. In the value field in the LACE **lab result**, enter either the LACE Readmission Index calculated by acute care, or a risk category based on clinical assessment (**Low**, **Medium**, or **High** risk of readmission). Whatever solution you choose, it should be searchable so that a list of patients at high risk of readmission can be generated:

> **TIP:** For more information on how to add your own lab tests in Accuro, please refer to the Accuro online help section on Labs FAQ.

Potentially Better Practice 3.4: Develop a process to offer and manage follow-up care, as appropriate

Recording the offer of a follow-up appointment

It is recommended that you record whether or not a follow-up visit was booked. Add a detail in the Surgical/Medical History band to record if the patient **accepted** the offer of follow up, **declined**, **was unreachable** or had **no follow up required**.

Using this simple dropdown consistently will make follow up results searchable for future panel management and QI work.

Creating follow-up appointments

The clinic team contacts the patient to book an appointment and records the outcome in the EMR. If the team is able to reach the patient and book an appointment, the details are recorded in the **Appointment Details** window.

It is recommended that the clinic create an appointment type for hospital discharge follow up. This will allow the clinic to differentiate these types of appointments for future quality improvement activities. A single appointment type for **Hospital Discharge** may be sufficient, or you may prefer to be more detailed and differentiate between different types of follow up appointments. See the table below for possible appointment types to use for different types of discharge notifications.

Possible Discharge Notification Appointment Reasons for the "Type" Field:

Type of Notification	Suggested Appointment Type
1. Hospital Discharge (recommended)	Hospital D/C F/U
2. Emergency Room Discharge	ER D/C F/U
3. Day Surgery Discharge	Day Surgery D/C F/U

Example:

Potentially Better Practice 4.1: Standardize entry of admit notifications, discharge notifications, and discharge summaries

How are admission and discharge notifications received in the EMR?

Admission and discharge notifications are sent to clinics either as [Connect Care Summative Notes](#), or by fax:

1. **Connect Care Summative Notes:** Connect Care Summative Notes are delivered electronically via eDelivery to the primary care provider (PCP) **identified by the patient** on admission to a **Connect Care enabled site**. They include:
   a. Specialty Consult Findings and Recommendations.

     b. Patient Discharge Summary.
     c. Emergency Department Provider's Notes.
     d. Post- Operative Notes.
     e. Labour and Delivery Notes.
     f. History and Physical.

For additional information on Connect Care Summative Notes, please see the following resources:

- [Summative Notes Electronic Delivery to Physician Electronic Medical Records](#)
- [Clinical Documentation to be Made Available from AHS to Primary Care Providers](#)

2. **Faxed Notifications**: Faxed notifications are available in some regions and may be received as an e-fax or as a paper fax.

Note: depending on circumstances providers may receive a combination of Connect Care Summative Notes, and/or faxed notifications.

Using Accuro to manage incoming admission and discharge notifications

Recommended method: Connect Care Summative Notes and faxed hospital admission and discharge notifications should be recorded in Accuro in the same category of document. That way the clinic can easily identify patients with a notification received within the last 48 hours and complete any necessary follow-up steps. This will also make it easier to generate lists of admitted and discharged patients for panel management and quality improvement initiatives.

Potentially Better Practice 4.2: Standardize entry of patient risk for hospital readmission in patient record

Patient risk of readmission assessment

Before a patient is discharged from hospital, it is recommended that the acute care team complete a patient risk of readmission assessment to identify the patient's risk of readmission. The completed risk of readmission assessment should then be sent to the patient's primary care provider. The primary care provider's clinic should then record the assessment result in their EMR.

The EMR activities for this section are aligned with the recommendations for **Potentially Better Practice 3.3**. Please see that section for details.

Process Measure 4.1 and 4.2: #/% of discharged patients with risk assessment documented in the patient record

PBP 4.1 and 4.2 have a Process Measure that measures patterns and trends of how well a clinic is performing documenting risk of readmission assessment in the patient record. Understanding this performance can assist the clinic to improve on certain activities to improve the standardized entry of patients with risk of readmission assessments.

Start by determining your baseline to understand your current state by documenting patient risk of readmission assessment in the patient record. Determine an appropriate measurement interval (e.g., daily, weekly, monthly) and plot results to calculate a percentage: count ÷ total count.

**Using a ratio calculation can provide the following data:**

$$\frac{\text{the \# of patients with risk of readmission assessment documented in the patient record}}{\text{Total \# of discharged patients}} \times 100 = \begin{array}{l}\text{\% of discharged patients with} \\ \text{risk assessment documented in} \\ \text{the patient record}\end{array}$$

Saving this data to compare it with the next month for data analysis can assist the clinic to improve on documenting risk of readmission assessments in the patient record. Leverage measurement skills from your practice facilitator, if possible.

Finding the numerator and denominator for this calculation will require two different searches in Accuro:

Numerator

To find the numerator it will be necessary to find the number of discharged patients who had a risk of readmission score recorded their chart. The search might look something like this:
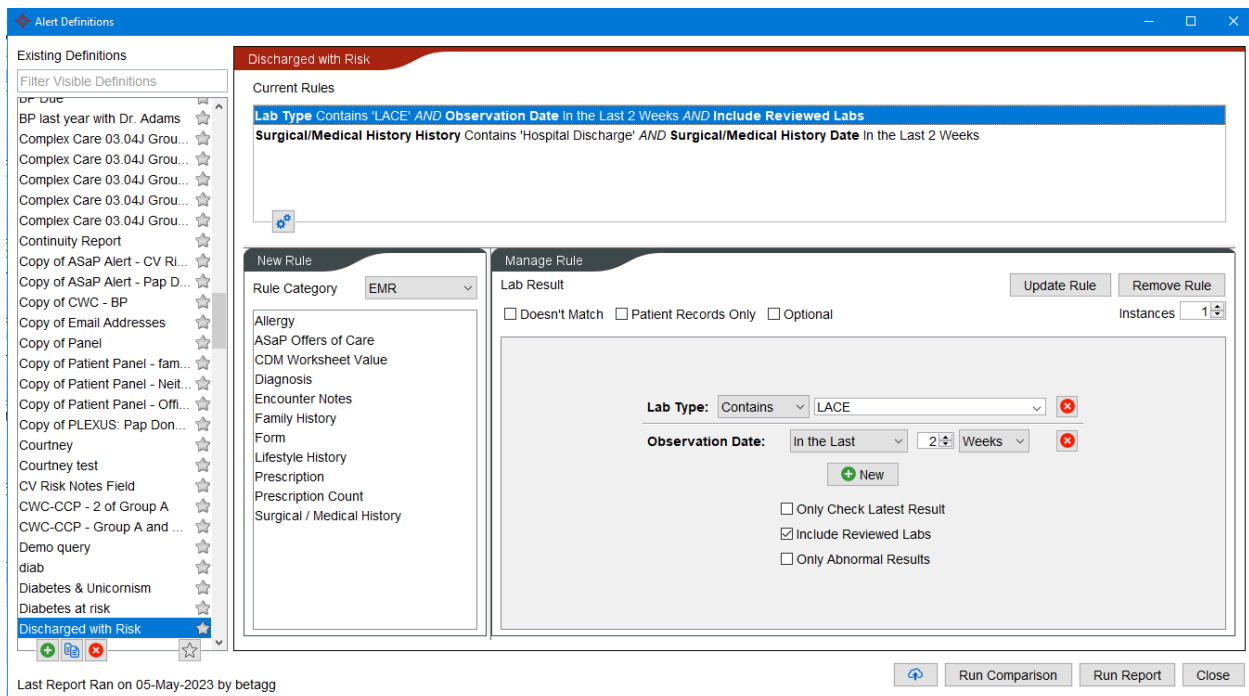
Denominator

The denominator is simply the number of discharged patients in the same time period and should be easier to find:

Potentially Better Practice 6.1: Develop a process to communicate with care providers outside of the medical home to facilitate transitions of care

The EMR activities for this section are aligned with the recommendations for Potentially Better Practice 2.1. Please see that section for details.

Outcome Measures

The purpose of H2H2H Transition is to assist primary care clinics in optimizing processes for paneled patients for effective transitions in care from home to hospital to home. H2H2H Transition outcome measure is to measure the impact changes have on % (#) of high risk of readmission patients with a visit within 14 days post hospital discharge. Gathering this data can identify patterns and trends for high risk of readmission patients that come into the clinic and assist the clinic to identify areas for improvement.

Start by determining your baseline to understand your current state. Determine an appropriate measurement interval (e.g., daily, weekly, monthly) and plot results to calculate a percentage: count ÷ total count.

Example measurement type: Methodology using ratio calculation

$$\frac{\text{the \# of patients that were scored as high-risk for readmission that had a clinic visit within 14 days of hospital discharge}}{\text{the total \# of patients that were scored as high-risk of readmission upon hospital discharge}} \times 100 = \text{\% of high-risk patients with a visit within 14 days post hospital discharge}$$

Saving this data to compare it with the next month for data analysis can assist the clinic to improve on certain activities. Leverage measurement skills from your practice facilitator, if possible.

To do this in Accuro, you'll need to create some queries in the Query Builder to find the numerator and denominator for the equation above.

Numerator

The numerator calculation is complex. It assumes that the EMR has reliable and searchable information for patient discharges, readmission risk scores and visits. It will also require some work outside of the EMR. Since Accuro cannot generate a report that will look individually at each discharge to see if a visit has taken place within 14 days, two reports will be needed. One to generate a list of patients with discharge tasks with high risk of readmission observations, and one to generate a list of patients with high risk of readmission observations and visits. Once you have these two lists you will need to compare the discharge dates with the visit dates to see who was seen within fourteen days and who was not.

The numerator searches might look something like this:

Patients with **Discharge** notice in their medical history AND **high risk of readmission** observations:

Patients with **Visits** AND **high risk of readmission** observations:

Once the two lists are generated, they'll need to be compared to match patients to see who had a high risk of readmission discharge followed up with a visit, and who did not.

Denominator

The search for the denominator is the same as the first search above: the number of patients with high risk of readmission who have had a discharge within a 14-day period.

> **Note:** It will be important to set the date ranges for these searches in the past to not include discharges where the patient hasn't yet had the opportunity to come in for follow-up. Using the example above of a 14-day period, the start of the date range should be at least 28 days in the past so that the end date is 14 or more days in the past.

Tips on Process Maintenance

Manually auditing some of your Search results to ensure they are producing accurate results is also a good time to review how well your clinic staff and physicians are following the discharge processes you've all agreed on. For example, you may find that your 14-day follow-up percentages are lower than expected according to your Search results, but then discover that not all of your clinicians are recording risk of readmission assessment correctly, so now your Search is inaccurate. Check in with any users that aren't following the process and get feedback on why not everyone is following the proper steps. They may just need a refresher, they may be new staff and this process was overlooked during their training, or the process itself might not flow well with their workflow. In the latter case, consider asking some of those users to help co-design an updated process that will flow better, while still allowing you to have searchable results.

Balancing Measure

A balancing measure determines the impact of a change on a separate part of the system and whether unintended consequences from changes to improve one part of the system have caused new problems elsewhere in the system.

Did the changes made to improve clinic follow-up appointments for patients within 14 days post-hospital discharge have unintended consequences elsewhere in the system?

Using your EMR, determine Third Next Available Appointment (TNA) for each provider by counting the TNA weekly. It will be important to know if new processes designed to improve follow up care for transitioning patients has a negative effect on provider's overall TNA.

Measuring TNA in Accuro can be a challenge. While a search for TNA is conceptually possible, in practice creating accurate searches for available appointments is difficult. Custom schedule templates and appointment types can make TNA searches unreliable. Since it is quick and easy to manually scan a provider's schedule for the third next free appointment, we recommend doing this process manually.

Notes for Determining TNA:
TNA should be collected on the same day of the week (month) and at approximately the same time.

Carve-outs are appointments held for specific kinds of patients or clinical needs. These time slots should not be included when counting TNA as they are in essence being held for special circumstances and can only be filled for and by the identified specific need.

Determine the length of your shortest appointment slot offered (e.g., 10 minutes). Longer appointments are comprised of multiples of these building blocks.

When counting the TNA weekly, look to see when the third next available empty building block is. Remember patient perspective of the wait is critical and so we must count the weekend.)

For more H2H2H tools and resources, please see the H2H2H Change Package.