

EMR Guide: Healthquest

Home to Hospital to Home Transitions

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Introduction

This electronic medical record (EMR) guide will provide recommendations about how to utilize the Microquest Healthquest 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 QHR Accuro, AVA, Microquest Healthquest, Telus PS Suite, and Telus Wolf 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 Healthquest](#) 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.

Standardized Text

Wherever possible teams should use standardized text or drop down (e.g., Worklist Tasks). This may take include Auto Completes or Macros which specify standardized text that can be dropped into free text fields. For more information about how to use Auto Completes or Macros in Healthquest see the online help files (e.g., F1 while using Healthquest).

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 Healthquest is to record the exchange of information in a **Care Coordination Worklist**. Using a worklist template created for the purpose of instructing staff to share specific information with the hospital upon admission guides the team in doing this work and allows for it to be monitored until complete. Possible text for the task is **Share Information with Hospital**.



Figure 1. H2H2H Transitions Change Package Summary

Example Care Coordination Worklist for sharing information with hospital upon admission.

Worklist Entry

Templates: Site: **Site 2** Employee: **Bonner, Clark** Doctor: **COOPER** Job Class: **Receptionist**

Template Name	Template Group	Task Type	Employee	Job Class	Practitioner	Site
Call Patient		Phone Patient		Nurse	BONNER	All Sites
Check Vitals		Check for information				All Sites
Rebook INR		Recall pt for appt		Receptionist		All Sites
Six Month Recall		Recall pt for appt		Receptionist		All Sites
Admit Care Coord	Care Coordination	Share Info with Hospital		Receptionist		All Sites
CC Risk Assessment	Care Coordination	Check for information				All Sites
Post Discharge Recall	Care Coordination	Post discharge pt follow-up				All Sites

Copy to All Employees Copy to Job Class

Description: **Care Coord Share with Hospital** Task: **Share Info with Hospital**

Employee: **[Redacted]** Client: **Smith Test**

Job Class: **Receptionist** Status: **Pending**

Doctor: **[Redacted]** Priority: **High**

Start Date: **March 24, 2023** Due Date: **March 25, 2023** Time: **[Redacted]**

Recurring Task: **[Redacted]** Days Return To: **[Redacted]** or **[Redacted]** Confidential

Notes: **[Redacted]** Re: **[Redacted]**

Client Card | Chart

Chart: 1262
Address: 101 Jamaica Ave.
City: Edmonton
Province: AB

Home Phone: (780)555-1234
Bus Phone: (780) -
Other Phone:
PHN: 904252220
Date of Birth: 15-04-1970
Age: 52
Gender: M
Last Appt: Mar 23, 2023 11:15 am
Default Doc: Dr. Clark Bonner

Note: It is recommended that the clinic team review their naming and processes for home to hospital to home Worklist Tasks. The team should review their **Worklist Setup** of Tasks, as the tasks, description and **notes contain** fields are searchable in CDS Queries. The description and/or task names should provide clear instructions and be different for the various processes in this document: sharing information from the home clinic to hospital upon admission, determining the LACE score of patients post-discharge where acute care did not provide a score and follow-up for patients post-discharge.

Process Measure 2.2: Process exists for identifying patients discharged

Process measure 2.2 is a proposed process measure for PBP 2.2. When patients are discharged from the hospital, eNotifications are automated messages delivered directly into the physician’s Electronic Medical Record (EMR), with key healthcare information. 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.

The EMR activities for this process are very similar to those for **Potentially Better Practice 4.1**. Please see *Using Healthquest to Manage Incoming Admission & Discharge Notifications* in the Potentially Better Practice 4.1 section below.

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

Document all patient communication in the chart – who, when, outcome. The task to do the patient communication can be a Worklist Task for Post-discharge follow-up, for example.

Creating a **Worklist Template** can make data entry more efficient. Add a field for recording the LACE readmission index score or, if a risk score has not been provided on the discharge summary, an in-clinic calculated risk score of readmission.

Recording the risk of readmission in a way that is searchable in Healthquest is important because the goal is to be able to generate a list of patients at high risk for readmission for 4.1 and 4.2 below.

If the readmission risk score (LACE score) is not provided on the report from acute care and a team member is tasked with determining the risk, a **templated Worklist task** to a team member, such as a nurse, would guide that work.

Example of a worklist task to **Calculate the Readmission Risk** of a discharged patient.

The screenshot shows the 'Worklist Entry' window with the following details:

- Templates:** Site: Site 2, Employee: Bonner, Clark, Doctor: COOPER, Job Class: Receptionist.
- Table:**

Template Name	Template Group	Task Type	Employee	Job Class	Practitioner	Site
Check Vitals		Check for information				All Sites
Rebook INR		Recall pt for appt		Receptionist		All Sites
Six Month Recall		Recall pt for appt		Receptionist		All Sites
Admit Care Coord	Care Coordination	Share Info with Hospital		Receptionist		All Sites
Post Discharge Recall	Care Coordination	Post discharge pt follow-up				All Sites
Readmission Risk Calculation	Care Coordination	Calculate Readmission Risk	Cooper, Kristie			Site 2
- Task Details:**
 - Description: Determine Readmission Risk LACE
 - Task: Calculate Readmission Risk
 - Employee: Cooper, Kristie
 - Client: Smith Test
 - Job Class:
 - Status: Pending
 - Doctor:
 - Priority: Med
 - Start Date: March 24, 2023
 - Due Date: March 26, 2023
 - Time:
- Notes:** Calculate LACE score to determine the risk of readmission if not provided by AHS
LACE Score:
- Client Card:**
 - Chart: 1262
 - Address: 101 Jamaica Ave.
 - City: Edmonton
 - Province: AB
 - Home Phone: (780)555-1234
 - Bus Phone: (780) -
 - Other Phone:
 - PHN: 904252220
 - Date of Birth: 15-04-1970
 - Age: 52
 - Gender: M
 - Last Appt: Mar 23, 2023 11:15 am
 - Default Doc: Dr. Clark Bonner

Once the readmission risk score is calculated in clinic, it should be added to the **Notes** in the worklist task as this is a searchable field in CDS queries.

TIP: For more information on how to create Worklist templates in Healthquest please refer to the Healthquest Online Help (F1) called **Adding/Editing Worklist Templates**.

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 a follow-up visit is accepted and booked. A **Worklist template** for post-discharge follow-up task should be created to record if the patient accepted the offer of follow-up, declined, was unreachable or had no follow-up required. It is important to add the LACE risk score to this task as this will be the method to search for patients at high risk for process measures 4.1, 4.2 and 6.1.

Worklist Entry

Site: **Site 2** Employee: **Bonner, Clark**
 Doctor: **COOPER** Job Class: **Receptionist**

Template Name	Template Group	Task Type	Employee	Job Class	Practitioner	Site
Call Patient		Phone Patient		Nurse	BONNER	All Sites
Check Vitals		Check for information				All Sites
Rebook INR		Recall pt for appt		Receptionist		All Sites
Six Month Recall		Recall pt for appt		Receptionist		All Sites
Admit Care Coord	Care Coordination	Share Info with Hospital		Receptionist		All Sites
Post Discharge Recall	Care Coordination	Post discharge pt follow-up				All Sites
Readmission Risk Calculation	Care Coordination	Calculate Readmission Risk Cooper, Kristie				Site 2

Copy to All Employees Copy to Job Class

Description: **Contact Patients** Task: **Post discharge pt follow-up**
 Employee: _____ Client: **Samantha Test**
 Job Class: _____ Status: **Pending**
 Doctor: _____ Priority: **Med**
 Start Date: **March 29, 2023** Due Date: **March 29, 2023** Time: _____

Recurring Task: _____ Days Return To: _____ or _____ Confidential

Notes: Re:

Patient was discharged from:
Patient LACE Score
 Ask regarding concerns:
 Time to act on this:
 Offer follow-up appointment. What is patient response?

Chart: 1292
 Address: 5555 Bluebird Cres
 City: Edmonton
 Province: AB
 Postal Code: T7Z 1R4
 Home Phone: (780) -
 Bus Phone: (780) -
 Other Phone: (780) -
 PHN: AB-Not entered in HQ
 Date of Birth: 01-01-1990
 Age: 33
 Gender: F
 Last Appt: Oct 15, 2021 11:15 am
 Default Doc: Dr. Clark Bonner

Note on Alternative Method of Recording the LACE Score for hospital readmission: If a clinic team is familiar with and has common clinic workflows around manual lab results, creating a manual lab entry for the LACE score is an alternative method of recording this result instead of the worklist entry. Lab results are searchable in CDS Queries. Use CDS Query Setup to build queries around a manual lab result instead of a Worklist task.

Creating follow-up appointments

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

Type of eNotification	Suggested Appointment Reason
1. Hospital Discharge (recommended)	Post-discharge FU
2. Emergency Room Discharge	ER Discharge FU
3. Day Surgery Discharge	Day Surg Discharge FU

Example:

Thu Mar 23, 2023 11:15 AM - TEST

Test, Smith
 Chart no: 1262
 DOB: Apr 15, 1970 Age: 52 Gender: Male
 PHN: 904252220 Valid Alberta Patient

101 Jamaica Ave.
 Edmonton AB

Home: (780)555-1234
 Work: (780) -
 Other: () -
 Email:

7 Notifications Pending + 10 OVERDUE TASKS

Last Major Visit: N/A
 Last Visit: Sep 26, 2022 - 178 days ago
 Next Visit: May 22, 2023
 Referral Doc:
 Default Doc: BONNER Verified: 10-02-2022

Appointment Details

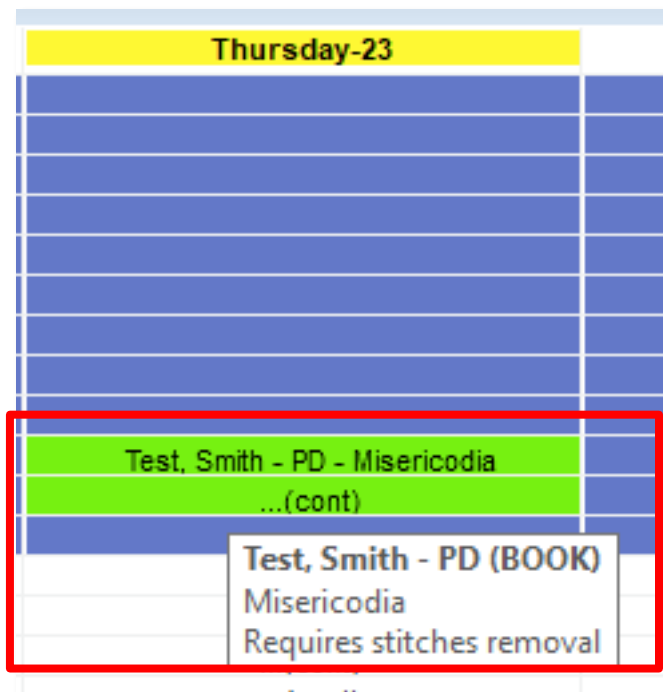
Time Req: 00:30 Visit:

(none) Booked See Receptionist
 Driver Medical Confirmed
 Emergency-Walk In Arrived
 Endoscopy In Room
 Full Medical Left Clinic
 New Patient Done
 Post-discharge FU Cancelled
 Prenatal Missed
 Repeat Exam
 Wart Removal

Method:
 In-Person
 Phone to:

Discharged from Misericordia
 Requires stitches removal

The type of appointment will display in the schedule for the provider and notes can be viewed while hovering.



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 [CII/CPAR eNotifications](#), [Connect Care Summative Notes](#), or by fax:

1. **eNotifications:** Providers participating in CII/CPAR receive eNotifications, which are automated messages delivered directly into the physician's EMR. eNotifications provide physicians with information about key healthcare events for their CPAR-paneled patients, including emergency room discharges, hospital admissions or discharges and day surgery discharges. eNotifications can be received in the EMR daily at 6 a.m. and similar to electronic lab reports.

Note that eNotifications about a patient are only sent to the provider who is identified as that patient's primary provider in CPAR. If a patient is paneled to more than one provider in CPAR, an eNotification will be sent to each of those providers. For providers working at different locations, eNotifications are sent to the location where each patient's panel is maintained and submitted to CPAR.

For additional information on eNotifications, please see the following resources:

- [eNotification Info Sheet](#)
- [eNotifications](#) - 3 min video

2. **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:
- Specialty Consult Findings and Recommendations.
 - Patient Discharge Summary.
 - Emergency Department Provider's Notes.
 - Post- Operative Notes.
 - Labour and Delivery Notes.
 - 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](#)

Note that the criteria for receipt of Summative Notes and eNotifications are different. As a result:

If a patient goes to an AHS facility on Connect Care:

- The CPAR provider receives an eNotification via CII.
- The patient identified PCP receives summative notes via eDelivery.
- **The patient identified PCP *may or may not* be the CPAR primary provider.**
 - So:
 - If the patient and CPAR PCP are the same, the PCP gets both notifications.
 - If the patient and CPAR PCP are different, then they each get one notification.

If a patient goes to AHS facility on a legacy system:

- CPAR primary provider would receive notice of:
 - ED discharge.
 - Inpatient admission and discharge.
 - Day surgery discharge.
- No summative notes documents are routed via eDelivery because the facility is not yet on Connect Care.

3. **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 eNotifications, Connect Care Summative Notes, and/or faxed notifications.

Using Healthquest to manage incoming admission and discharge notifications

Recommended Method: CII eNotifications, Connect Care Summative Notes of a Patient Discharge Summary and faxed hospital admission and discharge notifications should be recorded in Healthquest as a Worklist Task of **Post-discharge pt follow-up**. That way a clinic can easily identify patients with a notification received in the last 48 hours and complete any necessary steps.

Upon receipt of the notice in the provider's communication window in either Lab Results or Documents, creating the Worklist Task allows the tracking of discharge and follow-up.

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 as suggested in the [Recording the Assessment Tool Results](#) section.

Once approach would be to use:

- Patient LACE Score Low.
- Patient LACE Score Medium.
- Patient LACE Score High.

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.

Example measurement type: Methodology using ratio calculation

$$\frac{\text{the \# of patients with risk of readmission assessment documented in the patient record}}{\text{the total \# of discharged patients}} \times 100 = \text{\% of discharged patients with risk of readmission assessment documented in the patient record}$$

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 queries in Healthquest:

Numerator

To find the numerator it will be necessary to find the **number of discharged patients who had a risk of readmission score recorded**. The search might look something like this if risk readmission score is recorded in the post discharge follow-up task:

The screenshot shows the 'CDS Query Setup' window. The left pane lists three worklists under the heading 'Discharged Patients Readmission Risk Assessed':

- Worklists In the last 1 Months Notes: LACE Score High Task: Post discharge pt follow-up
- OR Worklists In the last 1 Months Notes: LACE Score Medium Task: Post discharge pt follow-up
- OR Worklists In the last 1 Months Notes: LACE Score Low Task: Post discharge pt follow-up (highlighted in blue)

The right pane shows the 'Worklists' configuration with the following settings:

- Logical Operator: OR
- Description: Worklists In the last 1 Months Notes: LACE Score Low Task: Post discharge pt follow-up
- Level: 1
- Data Desc: (empty)

Below the panes, the 'Worklists' section includes the following filters:

- Description: (empty)
- Notes contain: LACE Score Low
- Priority: (empty)
- Status: (empty)
- Due Date: In the last 1 Months
- Task: Post discharge pt follow-up
- Job Class: (empty)
- Employee: (empty)
- Doctor: (empty)

Other options are recording the risk score in the task description instead of the notes.

Denominator

The denominator is simply the **number of discharged patients in the same time period**. This query is looking to identify the patients from the received lab result (e.g., CII eNotification, AHS Summative Note of Discharge Summary, or Scan):

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: $\text{count} \div \text{total count}$.

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 Healthquest, there are various approaches you can take. One approach is to develop a query to identify all the patients that were discharged and determined to be high risk for readmission and another to query their visits to the clinic. Do this query per provider's panel.

What makes this challenging is that the results will have to be visually scanned and sorted to determine if the appointment was within 14 days of discharge.

Because the appointment is to within 14 days of discharge, it would be recommended to run a query 15 days into the next month to evaluate the previous month. For example, to determine the results for January run the query mid-February. Because Healthquest can query **in the last X months**, use 2 months as your time frame and only looks at those patients who were discharged in a given month.

Example query to identify patients at high risk of readmission with a visit post hospital discharge in the period being evaluated:

CDS Query Setup

Buttons: New Line, Copy Line, Delete Line, Save Line, Undo, Run Report, Close

Hosp Discharge and High Risk for Readmission and appointment information

Appointment In the last 2 Months Done
 OR NOT Appointment In the last 2 Months
 AND (Scan In the last 2 Months Type: Patient
 Discharge Summary Notes: High Risk
 OR Lab Result In the last 2 Months
 Discharge Summary High Risk
 OR Lab Result In the last 2 Months
 Discharged From High Risk)

Description: Lab Result In the last 2 Months Discharged From High Risk
 Level: 2
 Data Desc: Last Result Date

Lab Results

Result Date In the last 2 Months
 Result Type: Discharged From Clients with Abnormal Results Only Last Result Only
 Result Value Greater Than or Equal to:
 Result Value Less Than or Equal to:
 Doctor:
 Test Description: High Risk

Show Data Last Result Date

To identify the patients that were identified as high risk in the worklist task for post discharge follow-up and had an appointment for post-discharge follow-up, the query could look like this.

CDS Query Setup

Buttons: New Line, Copy Line, Delete Line, Save Line, Undo, Run Report, Close

Discharged Patients with High Readmission Risk Assessed & Appointment

Worklists In the last 2 Months Notes: LACE Score
 High Status: Done Task: Post discharge pt follow-up
 AND Appointment In the last 2 Months Type: PDDone

Description: Appointment In the last 2 Months Type: PDDone
 Level: 1
 Data Desc: Last Appt Date

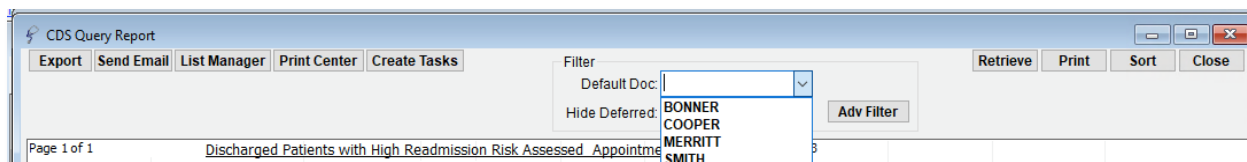
Appointments

Appointment Date In the last 2 Months
 Doctor:
 Appointment Type: Post-discharge FU
 Appointment State: Done
 Appointment Notes:

Show Data Last Appt Date

Important:

- By adding **Show Data** to lines of the query the appointment date, the appointment date will appear in the query results.
- Manually scan or export to a spreadsheet for analysis to compare the discharge date to the appointment date.
- When the results display, they can be sorted by Default Doc.



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 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 agreed upon 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 scheduler, 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 most EMRs 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](#).

Optional

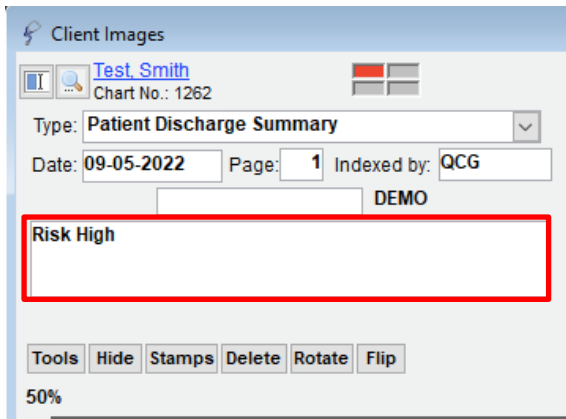
Tip: Highlight high risk patients in the received lab report or indexed scan/document to enhance visibility in the chart.

Received lab result with High Risk added as a note to the received result:

The screenshot shows a patient chart for 'Test, Smith' with a chart number of 1262. The interface includes a top navigation bar with buttons for 'View Client', 'Print', 'Undo', and 'Close'. Below this is a table of lab reports. The first row is highlighted in blue and has a red box around the 'High Risk' note in the 'User' column. The table has columns for Date, Description, Order Site, Reviewed, Date, and User. The 'User' column also contains a 'New' button and a 'Summary' button. The 'High Risk' note is a red-bordered box containing the text 'High Risk'.

Date	Description	Order Site	Reviewed	Date	User
Mar 23, 2023	AHS Patient Discharge Summary	All Sites	Yes		DEMO
Mar 23, 2023	Discharged From: Misericordia Hosp	All Sites	Yes		DEMO
Nov 18, 2021	Colonoscopy	All Sites	Yes		DEMO
Nov 18, 2021	Colorectal test offered	All Sites	Yes		DEMO
Oct 14, 2021	Colorectal test offered	All Sites	Yes		DEMO
Apr 20, 2020	RIFS Screen		Yes		DEMO
Apr 20, 2020	RIFS Screen		Yes		DEMO

Indexed and scanned document with high risk added as a note:



This will display in the patient's overview area:

