Avoiding Low Acuity Emergency Room Visits: A Toolkit for Practices

March 2018

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Reducing Preventable Emergency Room (ER) Utilization

**Problem: Emergency Department Over-Utilization**

**Drivers of ED Utilization**
- Individuals are unsure where to seek care
- Lack of advice or information
- Proximity to ED alternatives
- Social factors (transportation, etc.)
- Poor care coordination
- Uncoordinated care (PCP unaware of visit)
- Mediation errors & other quality concerns
- High volume of potentially avoidable visits
- ED overcrowding
- Office hours (after hours & weekends)
- Directed to the ED by provider office

**Results of ED Utilization**
- Wasteful healthcare spending (increased cost)

**Focus: Low-Acuity Non-Emergent (LANE) Visits**

**LANE Definition**
- Visits for which a delay of several hours would not increase the likelihood of an adverse outcome.
- Sometimes referred to as preventable, inappropriate, non-emergent, or ambulatory care sensitive.

**On average, an ER visit costs 7 times more than receiving care for the same reason in a doctor’s office or clinic.**

**Opportunity: Decrease Inappropriate ER Utilization Through Coordinated Efforts**

**Action: Develop and implement a toolkit, measure progress**

- **Improve Access**
  - Survey patients to determine ease of access
  - Assess appointment slot utilization
  - Align appointment length with need
  - Create protocols for efficiency and working-in acute visits
  - Offer same-day and next-day appointment availability
- **Appropriate Triage**
  - Evaluate and refine processes for triaging patients who call with an urgent care need
  - Implement nursing telephone triage protocols
  - Update after-hours messaging
  - Use after-hours call service and/or nurse advice line
  - Provide access to a physician on-call for urgent patient needs
- **Inform & Educate**
  - Inform patients about clinic services, hours, and after-hours access
  - Post flyers and posters about where to seek care for routine, urgent, and emergency issues
  - Survey patients about recent ER use and discuss their responses
- **Local Collaborations**
  - Reach out to most frequented ERs to partner with physicians and administrators
  - Form partnerships with nearby urgent care clinics
  - Develop processes and protocols to standardize care:
    - Real-time notification of patient arrival
    - Streamlined process for follow-up in clinic
    - Shared determination with ER physician on treatment/admit decisions
- **Post-ER/ Hospital Follow-up**
  - Call patients after an ER visit or hospitalization to:
    - Understand reason for visit, identify questions/issues, review medications, schedule follow-up, provide education
    - Use a checklist for ER or hospital follow-up visits
    - Implement transitional care management services

**Sampled Data**

**Cost Driver Spot Analysis: Avoidable Emergency Department Use. Center for Improving Value in Health Care.**

**Percentage LANE Visits**

1. Sampled Data
INTRODUCTION

Emergency Departments are often used for reasons other than emergency care. Inappropriate and costly visits to the ER are associated with a number of preventable factors shown below, including lack of access to primary and specialty care, patients being uncertain where to seek care, poor care coordination, and social or behavioral factors.\(^1\) Low Acuity Non-Emergent (LANE) ER visits, defined generally as visits for which a delay of several hours would not increase the likelihood of an adverse outcome, account for 30% of all ER visits.\(^2\) Non-urgent visits often indicate insufficient access to coordinated care and result in unnecessary testing, treatment, and significant preventable costs to the healthcare system.\(^1\) An estimated $4.4 billion could be saved annually if non-urgent ER visits were seen in clinic settings.\(^2,3\) This estimate does not account for additional cost burden from over-utilization of ER visits for specialty care services.

It is important to recognize that a wide variety of patients may overuse ERs, and therefore, interventions to reduce ER use should be broad-based. Certain patient populations may warrant added attention. “Super-utilizers” (individuals with 4 or more ER visits per year) are a small group of patients (4.5%-8%) who account for an estimated 28% of all ER visits, increasing the potential impact of reduction efforts targeted at this population.\(^2\) Another potentially impactful target population is super-utilizers with behavioral health or substance abuse problems who account for approximately 12.5% of ER visits nationwide.\(^4\) Successful efforts to reduce unnecessary ER visits – and their associated costs – need to be addressed by increasing access to both primary and specialty care services in a timely manner.\(^4\)

**Drivers of ER Utilization**

- Lack of established primary care
- Individuals are unsure where to seek care
- Office hours (after hours & weekends)
- Directed to the ER by provider/office
- Difficult/ Lack of Access
- ED Access required (EMTALA)—one stop shopping
- Lack of advice or information
- Lack of proximity to ER alternatives
- Poor Care Coordination
- Social Factors (transportation, etc.)

**Results of ER Utilization**

- High volume of potentially avoidable visits
- Wasteful healthcare spending (increased cost)
- Longer visit time & out of pocket patient cost
- ER Overcrowding
- Uncoordinated care (PCP unaware of visit)
- Medication Errors & Other Quality Concerns
- Lack of Follow Up from PCP (awareness, etc.)

**References:**

TOOLKIT PURPOSE AND DESIGN

This toolkit is designed for both primary care and specialty practices. It was developed to assist practices with incorporating new processes and tools into their current operations, in an effort to reduce inappropriate use of ERs, particularly for low-acuity conditions that could be cared for in the clinic setting. The toolkit is oriented toward reducing excess ER visits for all patient groups, not just super-utilizers or patients with behavioral or substance-related problems. Many of the strategies in this toolkit are also relevant for reducing potentially avoidable hospitalizations or hospital readmissions.

Reducing ER visits is not an easy task, but by using the strategies and tools provided within this toolkit, practices will be able to take steps towards addressing this issue. The recommended approach is to assess the current procedures in your practice, as well as the primary drivers for avoidable ER visits among your patients, and then make improvements to reduce excess ER visits. Based on your assessment, you are encouraged to determine which of the resources in this toolkit best fit the needs of your practice and your patient population. These resources are intended to be edited as needed to meet your specific needs.

The toolkit contains approaches that range from foundational to advanced. Foundational tactics are basic and can be implemented with minimal finances, technology, and staffing. Advanced tactics require more coordination or resources. By providing a range of tactics, this toolkit seeks to provide the opportunity for all practices to impact their avoidable ER visits no matter their current resource level.

Examples of approaches to reducing excess ER use, by level of difficulty

<table>
<thead>
<tr>
<th>Foundational</th>
<th>Intermediate</th>
<th>Advanced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey patients to determine ease of access</td>
<td>Offer same-day and next-day appointments</td>
<td>Expand office hours for evening and/or weekend care</td>
</tr>
<tr>
<td>Train staff to work-in acute visits</td>
<td>Implement nurse telephone triage protocols</td>
<td>Partner with local urgent care centers and ERs</td>
</tr>
<tr>
<td>Educate patients about when to use clinic, urgent care, or ER</td>
<td>Use an after-hours call service</td>
<td></td>
</tr>
<tr>
<td>Update after-hours messaging</td>
<td>Call patients after an ER visit or hospitalization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Survey patients about recent ER use</td>
<td></td>
</tr>
</tbody>
</table>

In order to successfully reduce excess ER visits and sustain those improvements, it is important to engage all members of the staff to work together to meet patients’ needs. To get started, please complete the practice assessment on the next page to identify potential opportunities within your practice that can be addressed through the resources in this toolkit.
PRACTICE ASSESSMENT

This assessment will assist in evaluating current practice operations that may affect ER utilization. It can be used as a baseline and to highlight opportunities for improvement.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Action/Opportunity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Does the practice hold slots in the schedule for same-day</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>appointments?</strong> <em>(If yes, how many per day, on average, per provider)</em></td>
<td></td>
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<tr>
<td><strong>Does the practice offer extended hours?</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>o Evening hours <em>(after 5pm)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Weekend hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How does the practice handle calls during office hours?</strong> <em>(Check all that apply)</em></td>
<td></td>
<td></td>
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<tr>
<td>o Caller uses interactive voice response system or push button system, before speaking with someone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Messages are collected and given to RN/MD/APP</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>o Calls are answered or transferred directly to staff who use a decision tree to guide next steps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Calls are answered or transferred directly to staff without use of a decision tree to guide next steps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Practice has no standard process in place</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How does the practice handle calls after hours?</strong> <em>(Check all that apply)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Patient contacts provider directly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Patient calls are screened by an answering service prior to speaking with provider</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Nurse provides advice to patient's on provider's behalf</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Practice directs patients to ER via recorded message</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Practice has no standard process in place</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The practice has a standard/reliable process for:</strong> <em>(Check all that apply)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Knowing when patients have visited the ER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Recognizing high ER utilizers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Educating patients on appropriate ER use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Providing information to patients on office hours, services, and after-hours numbers and services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Providing follow-up <em>(visits, communication)</em> within 1-2 weeks with patients who have recently visited the ER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Knowing when patients have been hospitalized</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Providing follow-up <em>(visits, communication)</em> within 2 weeks after hospital discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Tracking patients whom have been sent to the ER by the practice or answering service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Does the practice have a referral relationship with a retail or urgent care clinic for after-hours care?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MEASURING ER VISITS & HOSPITAL ADMISSIONS

To evaluate the success of practice improvement efforts aimed at reducing excess healthcare utilization, it is important for a practice to track what percent of their patients have recently visited an ER or been hospitalized. Unfortunately, it is difficult to obtain these data through a computer generated report because patients may use different facilities, and the data are usually not linked.

We recommend that practices directly measure ER visits and hospitalizations by asking patients these questions at the time of check-in or intake:

1. “Have you been to an Emergency Room as a patient in the last 3 months?”
2. “Have you been hospitalized in the last 3 months?”

Asking patients directly has a couple of advantages. First, it captures ER visits or hospitalizations at any facility. Second, asking patients will help open a dialogue about the reason for the visit, and an opportunity to educate patients about other ways to have their urgent care needs met. Using a 3-month timeframe helps standardize measurement (as opposed to asking patients if they have been to an ER since they were last seen in the clinic).

Data Collection Process
- Ask every continuity patient coming in for an office visit (exclude new patients)
- Record data in the EMR or on paper for tabulation

Metric Definition
Every month, the practice can calculate the percentage of continuity patients who report having had an ER visit or hospitalization in the last 3 months. If a patient visits the clinic multiple times in a month, he or she should only be counted once. New patients should be excluded because the practice did not have an opportunity to intercede with their prior ER use. The metrics are defined as follows:

<table>
<thead>
<tr>
<th>Metric</th>
<th>Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ER Visit Rate =</strong></td>
<td>The total number of unique patients that answer “Yes” to the question: Have you been to an Emergency Room as a patient in the last 3 months?</td>
</tr>
<tr>
<td></td>
<td>The total number of unique patients that have a clinic visit during the reporting period</td>
</tr>
<tr>
<td><strong>Hospitalization Rate =</strong></td>
<td>The total number of unique patients that answer “Yes” to the question: Have you been hospitalized in the last 3 months?</td>
</tr>
<tr>
<td></td>
<td>The total number of unique patients that have a clinic visit during the reporting period</td>
</tr>
</tbody>
</table>

Potential Issues/Questions:

a. Is this relevant for subspecialty practices?
Both primary care and subspecialty practices play an important role in reducing ER visits, avoidable hospitalizations, and other forms of excess healthcare utilization. Every contact that a patient has with the health care system is an opportunity to understand factors that influence health behaviors that precipitate urgent and emergent care.
b. **This method excludes patients who do not come in for an appointment.**
   Although this approach does not capture every patient, it will still provide a useful way to track healthcare utilization rates and efforts to reduce excess visits.

c. **If a patient is admitted through the ER, should it be counted as an ER visit, hospitalization, or both?**
   If a patient was admitted to the hospital through the ER, only count this as an admission. Do not count this as an ER visit.
• Survey patients to determine ease of access
• Assess appointment slot utilization
• Align appointment length with need
• Create protocols for efficiency and working-in acute visits
• Offer same-day and next-day appointment availability
**PATIENT ACCESS SURVEY**

*Instructions: Please answer the following questions about your overall experience with Insert Practice Name during the past year.*

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>It is easy to schedule an appointment in a timely manner</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>When I call Insert Practice Name, my needs are met in a timely manner</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>When I have an urgent medical issue, I am offered a same-day or next-day appointment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>When scheduling a routine follow-up appointment, I am offered an appointment that meets my needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>I know how to get in touch with someone from my doctor’s office after normal business hours</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If Insert Practice Name offered appointments during evening hours, I would use them</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If Insert Practice Name offered appointments during weekend hours, I would use them</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Things to consider as a team:**

- Are your patients satisfied with the current ease of access to your practice providers?
- Is there a need to offer evening hours?
  - If yes, is there a way to test out evening hours to determine value?
- Is there a need to offer weekend hours?
  - If yes, is there a way to test out weekend hours to determine value?
- Are your patients aware of how to contact their provider after hours?
There is not a perfect template or ‘one size fits all’ option when it comes to scheduling. Ideally, you want to increase capacity while making sure the practice isn’t slowed down, leading to longer patient waiting times or overtime. A good place to start is to assess current state of your practice’s appointment template and scheduling process.

**Step 1: Current Scheduling Process**

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>ANSWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is the average no show/cancellation rate?</td>
<td></td>
</tr>
<tr>
<td>2. What is the average appointment time scheduled?</td>
<td></td>
</tr>
<tr>
<td><em>(Ex: 15min, 30min)</em></td>
<td></td>
</tr>
<tr>
<td>3. Do physicals get 2 slots per patient?</td>
<td></td>
</tr>
<tr>
<td>4. Are new patient appointments designated in the current template?</td>
<td></td>
</tr>
<tr>
<td>a. If yes, what is the policy if that patient no shows or cancels?</td>
<td></td>
</tr>
<tr>
<td>5. What is the policy for an appointment slot that remains unfilled 24 hours prior to the time? <em>(Can staff work in patients?)</em></td>
<td></td>
</tr>
<tr>
<td>6. Does the provider block time to get caught up during the day?</td>
<td></td>
</tr>
<tr>
<td>7. What is the protocol for overbooking/double-booking for urgent care needs?</td>
<td></td>
</tr>
</tbody>
</table>
Step 2: Time Motion Study

Another important step in assessing the current state of your practice is to compare the length of scheduled appointments with the time actually spent. During a standard day, have one staff member be dedicated to measuring and recording how long each clinician and staff member spends with patients. A simple template to document observations and a stopwatch or cell phone is all that is needed. It is important to measure how long a provider is actually in the room with the patient. Most providers overestimate the time spent in a room.

Example Template:

<table>
<thead>
<tr>
<th>Task</th>
<th>Person</th>
<th>Start (Timestamp)</th>
<th>Stop (Timestamp)</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Patient vitals taken</td>
<td>Nurse</td>
<td>10:52</td>
<td>10:56</td>
<td>5 min</td>
</tr>
<tr>
<td>Example: Patient roomed</td>
<td>Nurse</td>
<td>10:57</td>
<td>10:58</td>
<td>2 min</td>
</tr>
<tr>
<td>Example: Nurse assessment</td>
<td>Nurse</td>
<td>10:59</td>
<td>11:06</td>
<td>8 min</td>
</tr>
<tr>
<td>Example: Physician assessment</td>
<td>Physician</td>
<td>11:07</td>
<td>11:26</td>
<td>20 min</td>
</tr>
<tr>
<td>Example: Patient check-out, payment, and follow-up appointment scheduled</td>
<td>Receptionist</td>
<td>11:27</td>
<td>11:34</td>
<td>8 min</td>
</tr>
</tbody>
</table>

At the end of the day, calculate an average for the time spent by providers during various appointment types.

Example Template:

<table>
<thead>
<tr>
<th>Appointment type</th>
<th>Avg Nurse Time (minutes)</th>
<th>Avg Physician Time (minutes)</th>
<th>Avg Total Time (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>10</td>
<td>36</td>
<td>46</td>
</tr>
<tr>
<td>Flu-like symptoms</td>
<td>6</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>Routine follow-up post-procedure</td>
<td>7</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Average appointment time</td>
<td>7.7 min</td>
<td>18 min</td>
<td>25.7 min</td>
</tr>
</tbody>
</table>

Do the observed times match the time blocked during appointment scheduling? Where can changes be made to optimize scheduling and create additional capacity that could be used for urgent care needs?
PROTOCOLS FOR EFFICIENCY AND WORK-INS

In addition to optimizing the patient scheduling template and process, standard protocols allow for increased efficiency in workflows and shared understanding among care teams. Consider the following areas to review, update, or create protocols:

- Treatment protocols for common conditions
  - Example: When a patient arrives for an acute visit for a UTI, can the staff that collects the sample also run the urine point of care test so that the results are ready for the provider?

- Standing orders
  - Example: Are standing orders in place for immunizations?

- Scheduling protocols
  - Are there medical concerns that are always acceptable to ‘work in’ during a normal day?
  - Under what conditions are staff allowed to ‘work in’ patients without asking permission?

The opportunity to streamline work and optimize efficiency helps ensure that adding walk-ins or same day appointments for urgent care needs will not slow the care team down or affect the timeliness of care for those patients who had regularly scheduled appointments. Engaging providers to work through these protocols makes it easier for staff to understand what is acceptable and encourages team-based care.

SAME-DAY AND NEXT-DAY APPOINTMENTS

Taking stock of your practice’s scheduling template and protocols, optimizing appointment length, and streamlining workflows should free up enough time to allow your practice to work-in some acute visits without any substantial changes to the template itself.

In addition, blocking several slots for same-day and next-day appointments will enhance access for patients with acute care needs. Optimal hours for same-day appointments are late morning/early afternoon. The average appointment time for primary care is 15 minutes, and many providers can offer 2-4 same day slots in their template to see patients for urgent concerns. If the practice offers early evening or weekend hours, these slots are also best utilized for urgent visits. The person handling triage of calls during the day or after hours should have access to these appointment slots for scheduling, either independently or with input from a nurse or physician.
• Evaluate and refine processes for triaging patients who call with an urgent care need
• Implement nursing telephone triage protocols
• Update after-hours messaging
• Use after-hours call service and/or nurse advice line
• Provide access to a physician on call for urgent patient needs
EVALUATE PROCESS FOR TRIAGING PATIENTS WITH URGENT CARE NEEDS

When patients or family members call the practice during business hours or after hours with an urgent care need, what is the current protocol?

Things to consider as a team:

- What is the current protocol for handling patient calls for an urgent care need?
- What is the process for deciding whether to offer a same-day or next-day appointment?
- Who is responsible for determining if an appointment is made?
- Is there an escalation process for which a patient would be transferred to a nurse?
- Is there an escalation process for which a patient would be transferred to a physician?
- Are there clear guidelines for when to tell a patient to go to the Emergency Room and what can be cared for by the practice?
- Are telephone triage protocols for common conditions an appropriate solution for your practice?
EXAMPLE PROTOCOL FOR PHONE TRIAGE: PEDIATRIC COUGH

Assessment Questions

Note to Triager - Respiratory Distress: Always rule out respiratory distress (also known as working hard to breathe or shortness of breath). Listen for grunting, stridor, wheezing, tachypnea in these calls. How to assess: Listen to the child's breathing early in your assessment. Reason: What you hear may be more valid than the caller's answers to your triage questions.

1. ONSET: "When did the cough start?"
2. SEVERITY: "How bad is the cough today?"
3. COUGHING SPELLS: "Does he go into coughing spells where he can't stop?" If so, ask: "How long do they last?"
4. CROUP: "Is it a barky, croupy cough?"
5. RESPIRATORY STATUS: "Describe your child's breathing when he's not coughing. What does it sound like?" (assess for wheezing, stridor, grunting, weak cry, unable to speak, rapid rate)
6. CHILD'S APPEARANCE: "How sick is your child acting?" "What is he doing right now?" If asleep, ask: "How was he acting before he went to sleep?"
7. FEVER: "Does your child have a fever?" If so, ask: "What is it, how was it measured, and when did it start?"
8. CAUSE: "What do you think is causing the cough?" Age 6 months to 4 years, ask: "Could he have choked on something?"

Triage Assessment Questions

1. Call EMS if:
   a. Difficult breathing AND SEVERE shortness of breath and shortness of breath present when not coughing
   b. Slow, shallow weak breathing
   c. Passes out or stopped breathing
   d. Bluish lips, tongue or face AND persists when not coughing
   e. Age < 1 year AND very weak (doesn’t move or make eye contact)
   f. Sound like a life threatening emergency to triager

2. Go to ER now if:
   a. Coughed up a large amount of blood
   b. Ribs are pulling in with each breath (retractions) when not coughing
   c. Stridor (harsh sound with breathing in) is present
   d. Lips or face have turned bluish but only during coughing fits
   e. Age < 12 weeks AND fever 100.4 or higher
   f. Difficulty breathing, not severe, still present when not coughing
   g. Age <3 years AND continuous coughing AND sudden onset today AND no fever or cold symptoms
   h. Rapid breathing (Breaths/min > 60 if < 2 mo; > 50 if 2-12 mo; > 40 if 1-5 years; > 30 if 6-12 years; >20 if > 12 years old)
   i. Age, 6 months AND wheezing is present but no severe trouble breathing
   j. SEVERE chest pain present now
k. Drooling/spitting out saliva AND can’t swallow fluids
l. Shaking chills and cough present for > 30 minutes
m. Fever > 104 axillary (or 105 by any route)
n. Fever and weak immune system
o. Child sounds very sick or weak to the traiger

3. See physician within 4 hours if:
   a. Age < 1 month AND lots of coughing
   b. MODERATE chest pain and can’t take a deep breath
   c. Age < 1 year AND continuous coughing keeps from feeding and sleeping AND no improvement from cough treatment guidelines

4. Call primary care provider now if:
   a. High-risk child (underlying lung, heart or neuromuscular disease)

5. See primary care provider within 24 Hours
   a. Age < 3 months
   b. Age > 6 months and mild wheezing but no trouble breathing
   c. Blood tinged sputum has been coughed up more than once
   d. Age > 1 year AND continuous coughing keeps from feeding and sleeping AND no improvement from cough treatment guidelines
   e. Earache is also present
   f. Age > 5 years AND sinus pain is also present
   g. Fever present > 3 days

6. See primary care provider when office is open (within 3 days)
   a. Age 3 to 6 months AND fever with cough
   b. Fever returns after gone for over 24 hours and symptoms are worse
   c. New fever develops after having a coughing for 3 days and symptoms get worse
   d. Coughing has cause chest pain that is present even when not coughing
   e. Pollen-related cough not relieved by antihistamines
   f. Cough only occurs with exercise
   g. Vomiting from hard coughing 3 or more times
   h. Coughing has kept child home from school for 3 or more days
   i. Nasal discharge for > 14 days
   j. Whooping cough present in the community, cough lasts for > 2 weeks
   k. Cough present for > 3 weeks

Provide home care recommendations and refer to other guidelines as applicable

EXAMPLE PROTOCOL FOR PHONE TRIAGE: ADULT HIGH BLOOD GLUCOSE

Assessment Questions

1. BLOOD SUGAR: "What is your blood sugar level?" ________________
2. ONSET: "When did you check your blood sugar?" ________________
3. USUAL RANGE: "What is your sugar level usually?" (e.g., usual fasting morning value, usual evening value) ________________
4. URINE KETONES: "Do you test your urine?" If yes, ask: "What does the test show now?" ________________
5. TYPE 1 or 2: "Do you know what type of diabetes you have?" (e.g., Type 1, Type 2, Gestational; doesn't know) ________________
6. INSULIN: "Do you take insulin?" If yes, ask: "Have you missed any shots recently?" ________________
7. DIABETES PILLS: "Do you take any pills for your diabetes?" If yes, ask: "Have you missed taking any pills recently?" ________________
8. OTHER SYMPTOMS: "Do you have any symptoms?" (e.g., fever, frequent urination, difficulty breathing, dizziness, weakness, vomiting) ________________
9. PREGNANCY: "Is there any chance you are pregnant?" "When was your last menstrual period?"

Triage Assessment Questions

1. Call EMS if:
   a. Unconscious or difficult to awaken
   b. Acting confused (disoriented, slurred speech)
   c. Very weak (can’t stand, etc)
   d. Sounds like a life-threatening emergency to the triager

2. Go to ER if:
   a. Vomiting and signs of dehydration (dry mouth, lightheaded)
   b. Blood glucose > 240 AND urine ketones moderate-large (if home testing)
   c. Blood glucose > 240 AND vomiting AND unable to check urine ketones
   d. New onset diabetes suspected (frequent urination, weight loss) AND vomiting or rapid breathing
   e. Vomiting last > 4 hours
   f. Patient sounds very sick/weak to the triager

3. See physician within 4 hours if:
   a. Fever > 100.5

4. Call primary care provider now if:
   a. Blood glucose > 400
   b. Blood glucose > 300 two or more times in a row
   c. Urine ketones moderate-large
   d. Caller has URGENT medication or pump question and triager is unable to answer the question

5. See primary care provider within 24 hours
   a. Symptoms of high blood sugar (frequent urination, weakness, weight loss) AND unable to test blood glucose
   b. New onset diabetes suspected (frequent urination, weakness, weight loss)

6. Call primary care provider within 24 hours if:
a. Call has NON-URGENT medication question

For each condition, give the appropriate home management advice.

**Modified pathway from** Thompson, David A. *After Hours Telephone Triage Protocols - Standard Adult*. Schmitt-Thompson Clinical Content. 2015.
Overview:
When patients or family members call the practice after hours, the message that they hear can influence whether or not they go to an Emergency Room to address their health concern. An effective after-hours message is an important element of the practice’s approach to reducing excess Emergency Room use.

Tips:
- The tone of voice matters. Use a calm, relaxed, and inviting tone when recording the message.
- Start out by explaining that a physician or advice nurse is always available if the patient cannot wait until the office opens.
- If the message must instruct patients to call 911 or go to the nearest Emergency Department, consider putting this at the end of the message, instead of the beginning.
- Know your patient population. The message may need to be recorded in Spanish or another language.

Below are three examples of good after-hours messages. Tailor your practice’s message to the resources you have in place.

1) **If your practice has a voice mail system and a doctor or nurse on call:**
   Thank you for calling [Practice Name]. We are currently closed. If you are calling about an urgent medical problem that cannot wait until regular office hours, there is a [doctor or nurse] available. Please call XXX-XXX-XXXX to reach the [doctor or nurse] on call.

   If your concern is less urgent and could be addressed when the office opens, please leave a message after the tone, or call back during normal office hours. Our office is open from XX:XX to XX:XX, and we will do our very best to address your needs.

   If you are calling about a life-threatening emergency, please call 911 or go to the nearest Emergency Room.

2) **If your practice has an answering service:**
   Thank you for calling [Practice Name]. We are currently closed. If you are calling about an urgent medical problem, please stay on the line to reach the [doctor or nurse] on call.

   If your concern is less urgent and could be addressed by your regular doctor or nurse when the office opens, please call back during normal office hours. Our office is open from XX:XX to XX:XX.

   If you are calling about a life-threatening emergency, please call 911 or go to the nearest Emergency Department.

3) **If your practice does not have someone on call after hours:**
   Thank you for calling [Practice Name]. We are currently closed. If you are calling about a medical problem that is not an emergency, please call back during normal office hours, and we will do our very best to address your needs. Our office is open from XX:XX to XX:XX. If you are calling about a life-threatening emergency, please call 911 or go to the nearest Emergency Room.
ASSESSING THE VALUE OF AN ANSWERING SERVICE OR NURSE ADVICE LINE

Consider using a medical answering service for continuous 24/7 coverage 365 days a year. Answering services can provide attentive receptionist services, schedule patient appointments, manage messages, and forward calls as appropriate. Many practices find peace of mind in knowing that they are always reachable by patients when needed while serving as a safety net for patient calls during normal business hours.

A nurse advice line is an option to consider as a means for guiding patients in making informed decisions on when and how to seek care. For example, this service may provide instructions ranging from self-care at home or calling 911 in the event of a true emergency. Triage call lines are often staffed by trained nurses guided by vetted standard protocols.

If your practice is considering hiring an answering service or nurse advice line...

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability</td>
<td>Is the service available 24/7, 365 days a year?</td>
</tr>
<tr>
<td>Cost of Service</td>
<td>Is this service included in any health plans your practice currently collaborates with?</td>
</tr>
<tr>
<td></td>
<td>Are there cost-effective options?</td>
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<tr>
<td>Timeline</td>
<td>What is the start-up time and preparation needed to go-live?</td>
</tr>
<tr>
<td>Impact on ED utilization</td>
<td>What are the estimated savings in unnecessary ER visits?</td>
</tr>
<tr>
<td>Population Scope</td>
<td>Is the service available to all practice patients?</td>
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<tr>
<td></td>
<td>Is there a buy-up option for patients who aren’t covered?</td>
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<tr>
<td>Scope of Services</td>
<td>Does this service cover both adult and pediatric concerns?</td>
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<tr>
<td></td>
<td>Is the service willing to share protocols for level of care needed?</td>
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<tr>
<td></td>
<td>Does the service provide a direct call to the practice when appropriate?</td>
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<tr>
<td>Quality &amp; Value</td>
<td>Are decision support tools used by staff?</td>
</tr>
<tr>
<td></td>
<td>What are the qualifications of the staff triaging patients?</td>
</tr>
<tr>
<td>Internal resources needed</td>
<td>Is there a need for internal IT support?</td>
</tr>
<tr>
<td>Data &amp; Measurement</td>
<td>Can the service provide reports on utilization?</td>
</tr>
<tr>
<td></td>
<td>Can the service measure and report on recommendations made?</td>
</tr>
<tr>
<td></td>
<td>• How many patients were referred to the ER?</td>
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<tr>
<td></td>
<td>• How many patients were transferred to schedule an appointment?</td>
</tr>
</tbody>
</table>
• Inform patients about clinic services, hours, and after-hours access
• Post flyers and posters about where to seek care for routine, urgent, and emergency issues
• Survey patients about recent ER use and discuss their responses
INFORM PATIENTS ABOUT CLINIC SERVICES AND HOURS

Often times, unnecessary ER visits are related to a lack of awareness by patients about where to seek care. Use regularly scheduled appointments as opportunities to educate patients about clinic services, hours, and types of issues that can be handled by the clinic rather than the ER.

Also consider using the following techniques to inform patients about their options for after-hours care:

- Update practice website or social media with after-hours guidelines and calling information
- Give new patients a new patient packet with information about the practice and what to do after-hours
- Give flyers or magnets to current patients at their appointments or send them out with annual physical reminders
- Add a footer to all patient documents with office and after-hours information
- Post flyers like those on the following pages, providing guidance on where to go for various types of problems
WHERE SHOULD YOU GO?
HOW TO CHOOSE BETWEEN:

**PRIMARY CARE**

$  
Call or see your doctor for your regular medical problems or most urgent needs
- Check-ups or physicals
- Common illnesses
- Flu shots and other vaccines
- Health advice
- Medication refills or changes
- Referral to a specialist
- Routine tests
- Your regular medical problems
...and most things on the urgent care list!

**URGENT CARE**

$$  
Go to the Urgent Care for common things that need to be treated soon, but your doctor is not available.
- Allergic reaction
- Animal or insect bite
- Back pain
- Bad cold or flu
- Cuts requiring stitches
- Ear aches
- Eye infection or irritation
- Mild fever
- Minor burns
- Nausea, vomiting and diarrhea
- Skin conditions
- Sore throat
- Sprains or strains
- Suspected broken bone, not shifted out of place
- Urinary tract infection

**EMERGENCY ROOM**

$$$$  
Go to the Emergency Room for serious life or limb threatening conditions.
- Broken bone, shifted out of place
- Coughing or vomiting blood
- Chest pain
- Difficulty speaking
- Head or eye injury
- Poisoning or overdose
- Severe abdominal pain
- Severe burns
- Signs of stroke such as numbness or weakness of limbs
- Shortness of breath
- Sudden loss of consciousness
- Uncontrolled bleeding
WHERE SHOULD YOU TAKE YOUR CHILD?

**PRIMARY CARE** $  
Call or see your pediatrician for regular medical problems or most urgent needs.

- Check-ups or physicals
- Common illness
- Flu shots and other vaccines
- Health advice
- Medication refills or changes
- Referral to a specialist
- Routine tests
- Your child’s regular medical problems

... and most things on the urgent care list!

**URGENT CARE** $$  
Go to the Urgent Care for common things that need to be treated soon, but your doctor is not available.

- Bladder infections
- Congestion
- Cuts requiring stitches
- Dehydration
- Ear aches
- Headache
- Mild Fever
- Minor burns
- Poor feeding
- Rash
- Sore throat
- Sports Injuries
- Stiff Neck
- Vomiting or diarrhea

**EMERGENCY ROOM** $$$$  
Go to the Emergency Room for serious life or limb threatening conditions.

- Broken bone, shifted out of place
- Difficulty breathing or speaking
- Head or eye injury
- Lethargic or hard to wake
- Loss of consciousness
- Poisoning or overdose
- Severe abdominal pain
- Severe asthma or allergic reaction
- Severe burns or laceration
- Traumatic injury
- Turning blue or pale

Call your pediatrician about:
- High fevers
- Persistent vomiting
PATIENT SURVEY FOR RECENT EMERGENCY ROOM USE

Instructions to practice:
- This survey is designed to help your practice understand more about patients’ use of Emergency Rooms. Learning more about why patients use the ER for non-emergencies can help your practice educate patients on appropriate ER use, and/or offer alternatives to the ER.
- We recommend that you ask patients at clinic check-in or during vital sign assessment if they have used an ER recently (e.g., since their last clinic visit, or in the last 3 months). If they say yes, then ask if they would be willing to complete a short survey.
- You can discuss answers with individual patients; collect the information to use in aggregate, or both. It is not necessary to survey all patients. Surveying 30-40 patients may be enough to see patterns.
- Feel free to modify the survey as you wish.

To help our clinic provide the best care possible, we would like to learn about your recent visit to the ER. Many visits to the ER are for true emergencies. However, sometimes people go to the ER for problems that could be taken care of in a clinic. Please tell us about your last visit to the ER. If you have been to the ER more than once recently, please think of the time that was the least serious.

1. What medical problem or symptoms were you having?
2. Which ER did you visit?
3. What day of the week did you go?
4. What time of day?
5. How did you get there? (called 911/ambulance, drove yourself, got a ride, etc.)
6. What did the doctors in the ER tell you was the cause of the problem?
7. Did the ER recommend any specific follow-up with our clinic or another doctor?
8. Did you or a family member try to call your doctor before you went to the ER?
   Circle: Yes or No
   a. If yes, who did you talk with (nurse, doctor, receptionist, etc.)?
   b. If no, why not?
9. Why did you decide on the ER?
10. Did you consider going to an urgent care, retail clinic, or walk-in clinic instead of the ER? Why or why not?
11. Is there anything our practice can do to better help you with urgent needs in the future?
LOCAL COLLABORATIONS

- Reach out to most frequented ERs to partner with physicians and administrators
- Form partnerships with nearby urgent care clinics
- Discuss processes and protocols to standardize care:
  - Real-time notification of patient arrival in ER
  - Streamlined process for follow-up in clinic
  - Shared determination with ER physician on treatment/admit decisions
PARTNERSHIPS WITH ERS AND URGENT CARE CLINICS

Partnerships with local ERs and urgent care clinics can lead to greater access to care for patients while minimizing additional burden to your practice’s providers. Collaboration through open communication, streamlined processes, and standardized protocols can provide peace of mind that this relationship is providing quality care to your patients.

Consider the following collaborative opportunities with local ERs and high-quality urgent care clinics convenient to your patients:

- Reach out to establish relationships at multiple levels:
  - Administrator-to-administrator for notification and information sharing
  - Clinician-to-clinician for shared standards and decision-making
  - Quality leader-to-quality leader for development of care plans and pathways

- Timely sharing of patient information
  - Protocols for timely notification of practice about patient visits to ER/urgent care
    - Notify practice when patients are seen at the ER/urgent care facility
    - Sharing of consult notes, test results, medication(s), etc. in standardized format
    - Sharing of care plan and/or defined information sheets for patients
  - Protocols for sharing information between facilities in a timely and HIPAA compliant manner

- Two-way referral relationship
  - Processes for patients who are uninsured or federally supported (ex: Women, Infants, and Children (WIC)) during normal practice business hours
    - Practice refers patients to urgent care clinic after hours
    - Clinic refers patients to practice if patient does not have primary care provider or specialty provider in your area
  - Create education materials for referral sharing

- Consider deeper collaboration focused on the needs of specific target populations such as
  - High ER utilizers and other high-cost patients
  - Chronically ill, complex patients
  - Patients with chronic pain

- Develop shared educational and informational materials
  - Flyers for guidance on where to seek medical care
  - Update after-hours messaging for practice
  - Add scripting to patient calls for care coordination/appointment scheduling efforts
  - Add information to websites
  - Add practice information to visit summaries at urgent care to promote follow-up

- Opportunities for collaboration around quality of care
  - Review urgent care clinic protocols, processes, care pathways, and quality/outcomes data
  - Sharing of best practices and protocols to standardize care
• Sharing of care plan and/or defined information sheets for patients established at both facilities
• Establish guidelines for testing/treatment, care management, and transition back to PCP
• Develop processes for routine review of information by clinicians and administrators in both facilities
  • Case review/Chart review
  • Measure and review utilization trends over time
    • Are patients accessing urgent care instead of ER after hours?
    • Are patients accessing urgent care instead of practice during business hours?
  • Measure and review quality trends over time
    • Are standardized protocols being followed?
    • Are patients satisfied with care received?
    • Is information being shared in a timely manner to promote care continuity?
• Discuss process improvement opportunities to continually improve
  • Are referral patterns changing over time?
  • Do adjustments need to be made to information sharing processes?
POST-ER/HOSPITAL FOLLOW-UP

• Call patients after an ER visit or hospitalization to:
  • Understand reason for visit
  • Identify questions/issues
  • Review medications
  • Schedule follow-up
  • Provide education about the appropriateness of the ER visit (if applicable)
• Use a checklist for ER or hospital follow-up visits
• Implement transitional care management services
PHONE CALL SCRIPT

Introduction
Hello Mr./Mrs. ____, this is _____, I am a nurse from ___________________. As part of our continued effort to make sure you receive the best care possible, I am calling to follow-up with you after your recent Emergency Room visit (or hospitalization). This should take about 10-15 minutes. Is this a good time to talk?
   - If yes, proceed
   - If no: Can you give me a time that would be better and I will call you back?

Discharge Instructions
I want to make sure the discharge instructions you received were clear and understandable...

1. Can you please tell me in your own words what your diagnosis was?
2. Can you please tell me in your own words how you are caring for yourself at home?
3. What questions do you have about your discharge instructions?

Medications
I would like to go over any changes to your medicines.

4. Were you started on any new medicines?
   a. If yes: Have you been able to fill your prescriptions?
5. Were you asked to stop or change any of your old medicines?
6. What questions do you have about your medicines?

Appointments & Follow-up Services
Making sure you stay well and have the right follow up after your ER visit is important.

7. When is your follow-up appointment? [Assist patient with scheduling if not already done]
8. Tell me about any equipment or services you have as a result of your visit.
9. Are there barriers to getting services, medical equipment, or to your next appointment?

For patients who went to the ER, these questions can be used to discuss appropriateness and alternatives:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Did you try to call your doctor before you went to the ER?</td>
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<tr>
<td></td>
<td>If yes, did anyone answer?</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>If yes, who did you talk to (nurse, doctor, etc)?</td>
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<tr>
<td>11. Did you consider urgent care, retail clinics, or walk-in options prior to going to the ER?</td>
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<tr>
<td></td>
<td>If yes, what made you decide on the ER?</td>
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<tr>
<td>12. Did anyone tell you to go to the ER?</td>
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<tr>
<td></td>
<td>If yes, who?</td>
<td></td>
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<tr>
<td></td>
<td>If yes, why (condition, to see a specialist)?</td>
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<tr>
<td>13. Did you know we offer sick/same day appointments for urgent needs?</td>
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</tr>
</tbody>
</table>
**Alternatives: Assessment of Knowledge and Education Provided**

**Education Points:**
- Your primary doctor should be your first call for anything that isn't life threatening. Often times your doctor’s office can offer same-day or next-day appointments.
- Urgent care clinics or walk-in clinics are another option. They are often located in grocery stores or pharmacies. Note these locations have hours beyond the typical 8a-5p and are open on the weekends.

14. Do you feel confident in your ability to determine where to seek care in the future?

**Example language:**

"There are some clear signs that a person should consider a trip to the Emergency Room. But sometimes you may be unsure of where you should go if you are having certain symptoms. We want you to be able to find the right place for your health care and ideally one that is close to you, where you can receive care quickly, and a place that financially makes sense for you."

**PEDIATRIC PATIENTS:** Our Pediatricians recommend you call them first before going to the Emergency Room. Many times they can give you advice over the phone and save a trip the Emergency Room. Most of those pediatric practices offer same-day service and are open extended hours on some evenings and weekends.

**Document Follow Up Resulting from Call**

Follow up as result of call

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient referred into Case Management Program</td>
<td>Yes</td>
</tr>
<tr>
<td>Medication related activities</td>
<td></td>
</tr>
<tr>
<td>Appointment related activities</td>
<td></td>
</tr>
<tr>
<td>Referral to other program/resources</td>
<td></td>
</tr>
<tr>
<td>Mailed patient education materials</td>
<td></td>
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<tr>
<td>Messaged/escalated to MD/NP/DO/PA</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
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</tbody>
</table>

Closing:
- Thank you for taking time to talk with me.
- Do you need anything else from us right now?
We wish you all the best in your recovery.
CHECKLIST FOR ER OR HOSPITAL FOLLOW-UP VISITS

This checklist is intended to serve as a guide for conducting follow-up for patients recently discharged from the ER or hospital. While it is most relevant for primary care clinics, it can also be used by medical specialty and surgical clinics, particularly when the ER visit or hospitalization was related to a procedure or condition followed by that practice.

This follow-up visit is important for several reasons. It provides the clinic an opportunity to assess the patient’s understanding of the condition for which they were treated, any changes to medications, and any issues that might require attention. If the patient is following up for an ER visit that might have been avoided, the follow-up visit also provides an opportunity to learn about the factors that contributed to the ER visit and educate patients about available alternatives (i.e. after-hours clinic availability).

The checklist is organized in stages: Prior to the visit, During the visit, and at the Conclusion of the visit.

Your practice is encouraged to adapt the checklist and tailor how it is used in your practice. For example, surgical or medical specialty clinics may wish to add items to the checklist related to post-procedure follow-up assessment. The list could become a template in your EHR or be used in paper format.

Your practice might consider dividing tasks from the checklist between the clinical and administrative staff. For example:

- Frontline staff call to confirm appointments
- Nurse/MA initiates the medication reconciliation process prior to the visit
- Physician arranges for home health services during the visit
Sample Checklist for ER or Hospital Follow-up Visits

Prior to the visit:
☐ Review discharge summary and/or ADT feed information, if available
☐ Initiate medication reconciliation
☐ Reminder call to patient or family/caregiver:
  □ Emphasize importance of the visit and address any barriers (e.g., transportation)
  □ Remind patient/family/caregiver to bring medication lists and all prescribed and over-the-counter medicines
  □ Provide brief instructions for seeking emergency and non-emergency after-hours care if the need arises prior to the scheduled appointment
  □ Coordinate care with home health care nurses and case managers (if appropriate)

During the visit, ask the patient/family/caregiver to explain:
☐ His/her goals for visit
☐ What factors contributed to the ER visit or hospitalization?
☐ Perform medication reconciliation:
  • What medication(s) is the patient taking? On what schedule? Were any medications added, stopped, or changed? Any side effects, need for monitoring, or other concerns?
  Determine the need to:
  □ Adjust medications or dosages
  □ Follow-up on test results
  □ Perform additional monitoring or testing
  □ Discuss specific future treatments
☐ Teach-Back:
  □ Instruct patient in self-management; ask patient to repeat back
  □ Explain warning signs and how to respond; ask patient to repeat back
  □ Provide instructions for seeking emergency and non-emergency after-hours care; ask patient to repeat back
☐ Provide educational material to guide patient self-management

At the conclusion of the visit:
☐ Print reconciled, dated medication list and provide a copy to the patient/family/caregiver, home health care nurse, and case manager (if appropriate)
☐ Communicate revisions to the care plan to patient/family/caregiver, health care nurses, and case managers (if appropriate)
  • Consider skilled home health care and other supportive services
☐ Ensure that the next appointment is made, as appropriate
  • Consider scheduling recurring visits for frequent users of the ER
☐ Provide after-hours care instructions and telephone number
  • Provide handout of locations if available

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2 The Post-Hospital Follow-Up Visit: A Physician Checklist to Reduce Readmission. Eric A. Coleman, M.D., M.P.H. October 2010, California HealthCare Foundation
http://www.rarereadmissions.org/documents/PostHospital_FollowUp_Visit.pdf


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Depression screening (PHQ-2 & PHQ-9)

Depressive symptoms are common in the context of acute illness and can contribute to ER use. The PHQ-2 and PHQ-9 are relatively short screening tools to assess depressive symptoms. They incorporate DSM-IV depression criteria with other leading major depressive symptoms.\textsuperscript{1} If a patient scores \( \geq 3 \) on the PHQ-2, then proceed to the PHQ-9.

Teach-Back

Regardless of a patient's health literacy level, it is important to verify that information has been explained well to patients, and that they have a shared understanding of what has been communicated. The teach-back method is a way of checking understanding by asking patients to state in their own words what they need to know or do about their health.\textsuperscript{2}

The following videos from the Institute of Health Improvement (IHI) explain the Teach-Back and “Ask, Tell, Ask” methods:

**Teach-Back:**


“Ask, Tell, Ask“:


\textsuperscript{2} AHRQ, “Health Literacy Universal Precautions Toolkit: Use the Teach-Back Method”. Feb 2015
ER/HOSPITAL FOLLOW-UP
Part 1: Transitional Care Management Services Workflow

Patient Discharged from ED/Acute Care Setting

Data Source: HIE, ADT, Hospital Portal, Fax

Practice Notified of ED/Admission Encounters?

Step 1
Practice Logs
Encounter in EMR and Tracking Spreadsheet

Complete interactive contact with patient within 2 business days per Script

Provide non face-to-face care management services

Element #1
Element #2

Step 2
Clinical Review of Data by Office Staff in preparation to execute Elements 1-3

Is patient moderate to high risk requiring follow up transitional care visit?

No

Is patient moderate to high risk requiring follow up transitional care visit?

No

No further action required

Yes

No further action required

Element #3

Step 3
Schedule Transitional Care Follow Up Visit within 5-7 Days

Step 4
Document Patient Visit Encounter

Step 5
For Medicare patients submit billing post discharge plus 30 days to receive payment for Transitional Care Visit. For all others submit per normal procedures
Part 2, Billing Requirements for Medicare Transitional Care Management Services

The following details provide CMS billing requirements for practices billing Transitional Care Management Services for Medicare Beneficiaries only.

A. Inpatient Setting

- For Medicare beneficiaries for which a practice intends to bill for Transitional Care Management Services, an inpatient setting includes: Inpatient Acute Hospital, Inpatient Psychiatric Hospital, LTAC, IRF, SNF, Hospital Outpatient Observation or Partial Hospitalization, or Partial Hospitalization at a Community Mental Health Center.

B. Interactive Contact

- Communication with patient, family, caregiver
- May be performed by staff under direct supervision of qualified professional. May be completed by RN, LPN, MA
- Staff must include capacity for prompt interactive communication addressing patient status and needs beyond scheduling follow-up care.
- Contact may be by telephone, email, or face to face
- Documentation to include date of contact or two failed attempts

C. Non Face to Face Services

- Services furnished by Physicians/NPs: review discharge summary, need for follow up pending tests & treatments, interact with other healthcare professionals, education to patient, family, guardian, caregiver, referrals or arrange for community resources, assist schedule follow with community providers
- Services furnished by clinical staff under direction of Physicians/NPs: communicate with agencies & community services, education to beneficiary, family, caregiver re self management, IDLs, ADLs, treatment regime and medication management, identify community and health resources, assist with accessing care and services

D. Face to Face Encounter

- CPT Code 99495 Transitional care management services with moderate medical complexity within 14 days of discharge
- CPT Code 99496 Transitional care management services with high medical decision complexity within 7 days of discharge

E. Medical Decision Making

Elements for Each Level of Medical Decision Making

<table>
<thead>
<tr>
<th>Type of Decision Making</th>
<th>Number of Possible Diagnoses and/or Management Options</th>
<th>Amount and/or Complexity of Data to Be Reviewed</th>
<th>Risk of Significant Complications, Morbidity, and/or Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

For more information about medical decision making, refer to 1995 Documentation Guidelines for Evaluation and Management Services or 1997 Documentation Guidelines for Evaluation and Management Services.

TRANSITIONAL CARE MANAGEMENT OUTREACH FORM

ER/Hospital Discharge Information

Patient name: ____________________________________________________
Date of contact: _____ /_____ /_____
Discharged from: ____________________________ on _____ /_____ /_____
Diagnosis/Problem ________________________________________________
Source of Information:
□ Patient/Family Name: ____________________________ □ Discharge Summary

Medication Reconciliation

Medication Changes: □ Yes □ No  New Medications: □ Yes □ No
Medication List Update: □ Yes □ No

Risk Assessment

<table>
<thead>
<tr>
<th>Clinical Diagnoses, Behavioral Health, Special Needs</th>
<th>Potential Physical Limitations</th>
<th>Social Determinants</th>
<th>Utilization</th>
<th>Clinical Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Any uncontrolled chronic condition</td>
<td>• Non-ambulatory</td>
<td>• Lack of financial support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Multiple co-morbidities</td>
<td>• Needs assistance with ADLs</td>
<td>• Lack of social support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Chronic pain</td>
<td>• Severely diminished</td>
<td>• Unemployed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Substance abuse</td>
<td>functional status</td>
<td>• Homelessness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Behavioral health diagnosis</td>
<td>• Declining eyesight</td>
<td>• No health insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Terminal Illness</td>
<td>• Extreme weakness or fatigue</td>
<td>• Low literacy or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advanced age with frailty</td>
<td>• At risk for falls</td>
<td>health literacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pre-term delivery of newborn</td>
<td></td>
<td>• Unsafe home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Patients with special needs</td>
<td></td>
<td>environment</td>
<td></td>
<td></td>
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<tr>
<td>• Poor dental health</td>
<td></td>
<td>• Lack of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dementia</td>
<td></td>
<td>transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Any uncontrolled chronic condition</td>
<td></td>
<td>• Language barriers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Multiple co-morbidities</td>
<td></td>
<td>• Lives alone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Chronic pain</td>
<td>• Non-ambulatory</td>
<td>• Frequent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Substance abuse</td>
<td>• Needs assistance with ADLs</td>
<td>hospitalizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Behavioral health diagnosis</td>
<td>• Severely diminished</td>
<td>(&gt;4/year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Terminal Illness</td>
<td>functional status</td>
<td>• Frequent ER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advanced age with frailty</td>
<td>• Declining eyesight</td>
<td>or urgent care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pre-term delivery of newborn</td>
<td>• Extreme weakness or fatigue</td>
<td>visits (&gt;4/year or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Patients with special needs</td>
<td>• At risk for falls</td>
<td>&gt;2/6 months)</td>
<td></td>
<td></td>
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<tr>
<td>• Poor dental health</td>
<td></td>
<td>• Multiple providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dementia</td>
<td></td>
<td>• Hospital readmission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Any uncontrolled chronic condition</td>
<td></td>
<td>within 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Multiple co-morbidities</td>
<td>• Non-ambulatory</td>
<td>• Major procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Chronic pain</td>
<td>• Needs assistance with ADLs</td>
<td>within 1 year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Substance abuse</td>
<td>• Severely diminished</td>
<td>• Chronic kidney</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Behavioral health diagnosis</td>
<td>functional status</td>
<td>disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Terminal Illness</td>
<td>• Declining eyesight</td>
<td>• Brain trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advanced age with frailty</td>
<td>• Extreme weakness or fatigue</td>
<td>• Expensive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pre-term delivery of newborn</td>
<td>• At risk for falls</td>
<td>medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Patients with special needs</td>
<td></td>
<td>• Polypharmacy (more than 6 chronic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Poor dental health</td>
<td></td>
<td>medications)</td>
<td></td>
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<tr>
<td>• Dementia</td>
<td></td>
<td>• High-risk-medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Any uncontrolled chronic condition</td>
<td></td>
<td>(insulin, anticoagulant, oral hypoglycemic, opioid)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Multiple co-morbidities</td>
<td></td>
<td>• Difficulty following treatment plan</td>
<td></td>
<td></td>
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<tr>
<td>• Chronic pain</td>
<td></td>
<td>• Difficulty taking medications as prescribed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Substance abuse</td>
<td></td>
<td>• Recent hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Behavioral health diagnosis</td>
<td></td>
<td>• Recent visit to a long-term facility? or other transition of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Terminal Illness</td>
<td></td>
<td>• Spouse recently deceased</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advanced age with frailty</td>
<td></td>
<td>• Low confidence in ability for self-management</td>
<td></td>
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</tr>
</tbody>
</table>
| • Pre-term delivery of newborn                      |                                | • Answers the question with “Yes”: Is this patient likely to be hospitalized in the next 30 days?

Follow-Up Actions

TC Appointment Date: □ None Needed □ Appointment Date: ____ /____ /____
Labs/Diagnostics: □ None Needed □ Ordered: ____________________________
Referrals: □ None Needed □ Referrals made to: ____________________________
Community Resources: □ None Needed □ HHA □ Hospice □ Area Agency on Aging
                      □ Other: ____________________________
DME: □ None Needed □ DME Ordered: ____________________________
Patient/Family Education: Topics Discussed: ____________________________
REFERENCES


Community Care of North Carolina. *Methods to Help Tackle Emergency Department Visits- Practice Toolkit*.


South Boston Community Health Center. *Emergency Diversion- Reducing Preventable ER Visits*.


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<thead>
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