Preventing Avoidable Readmissions Together (PART)

RESOURCE GUIDE

The PART Initiative is jointly sponsored by the South Carolina Partnership for Health and the North and South Carolina Quality Improvement Organization, The Carolinas Center for Medical Excellence
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INTRODUCTION TO SOUTH CAROLINA PARTNERSHIP FOR HEALTH
SOUTH CAROLINA PARTNERSHIP FOR HEALTH (SC PFH)

“For academic leaders, insurers and health care providers to come together statewide in South Carolina to tackle the Triple Aim, using a community collaborative approach, is a first in the nation.”

Maureen Bisagnano, president and CEO of the Institute for Healthcare Improvement

The South Carolina Partnership for Health is a nonprofit 501(c)(3) corporation that develops and implements targeted initiatives to improve the safety, quality and cost-effectiveness of health care in South Carolina. The three member organizations of this newly formed corporation are Health Sciences South Carolina (HSSC), Blue Cross BlueShield of South Carolina (BCBSSC) and the South Carolina Hospital Association (SCHA). The partnership seeks to enhance the competitiveness of South Carolina by improving the health of its citizens through a commitment to implementing health care improvements using evidence-based research results and accomplishments, and the Institute for Health Care Improvement’s “Triple Aim” Framework.

Triple Aim refers to three primary goals:

• Improving population health
• Enhancing patient experience
• Controlling the cost of health care
PREVENTING AVOIDABLE READMISSIONS TOGETHER (PART)

South Carolina Partnership for Health’s first focus - a program called *Preventing Avoidable Readmissions Together (PART)* - is a statewide effort to reduce hospital readmissions in South Carolina. The program is jointly sponsored by the South Carolina Partnership for Health (SC PfH) and the North and South Carolina Quality Improvement Organization, The Carolinas Center for Medical Excellence (CCME).

The goal of PART is to improve care transitions across South Carolina to reduce avoidable readmissions rates for patients with acute myocardial infarction, heart failure, pneumonia and chronic obstructive pulmonary disease by 20 percent by 2014. Failure to reduce avoidable readmissions will result in severe economic penalties from Centers for Medicare and Medicaid Services (CMS) through reduced reimbursement.

THE MISSION OF PART IS TO

- Support hospitals and communities to create a process map around the discharge process and identify areas of improvement
- Implement evidence-based practices to identify and correct gaps in the discharge process;
- Provide national and state expertise and support, resources and education to hospital’s staff and community partners as they collaboratively work to create their own customized care transition plan
- Provide a place for hospitals and communities to connect and develop transition strategies within their community
- Provide an infrastructure of experienced, clinical/translational investigators and population health experts and health economists to strategically address the acquisition of new knowledge and through its further development, deliver innovative, quality care

BENEFITS OF PARTICIPATING IN PART

PART provides hospitals free resources and tools from a nationally recognized care transitions program, BOOST (Better Outcomes for Older adults through Safe Transitions). While these materials would cost you thousands of dollars if purchased directly from BOOST, the South Carolina Partnership for Health is pleased to provide them to you at no cost. PART will augment any existing Hospital Engagement Network (HEN) programs in which you may already be engaged and provide you with robust services and resources including onsite and information technology support.

In addition to the Society of Hospital Medicine’s (SHM) Project BOOST resources, PART also offers hospital data collection through the Society’s data entry system, which will allow hospitals to track key processes and outcome measures.
FREQUENTLY ASKED QUESTIONS AND ANSWERS ABOUT SC PARTNERSHIP FOR HEALTH AND PART

WHAT IS THE PARTNERSHIP FOR HEALTH?
The SC Partnership for Health (SC PfH) focuses exclusively on health and health care in South Carolina. It is a collaborative partnership between SCHA, BCBSSC and HSSC to improve the health of all South Carolinians through the goals of the Triple Aim: improve the health of the population, enhance patient experience and control costs.

IS PARTNERSHIP FOR HEALTH THE SAME AS PARTNERSHIP FOR PATIENTS?
No. The Partnership for Patients is a national effort funded by the Agency for Healthcare Research and Quality (AHRQ) under the U.S. Department of Health and Human Services (DHHS). Hospitals participate in Partnership for Patients through regional Hospital Engagement Networks or HENs. Fifty-six South Carolina hospitals participate in the Premier HEN and are known as the South Carolina Affinity Group. The national Partnership for Patients effort and the statewide Partnership for Health share very similar goals and offer programs that at first glance may appear to be competing. However, this is not the case. While the goals of PART and the HEN are aligned, PART provides hospitals free resources and tools from a nationally recognized care transitions program. PART also provides on-site and technical support to participating hospitals.

WHAT IS THE PARTNERSHIP FOR HEALTH’S CURRENT FOCUS?
The first initiative developed by the SC PfH focuses on care transitions through the initiative called PART or Preventing Avoidable Readmissions Together. The PART initiative is jointly sponsored by SC PfH and CCME. SC PfH has already begun providing information through webinars, coaching sessions and on-site meetings. The response has been excellent, with about half of the state’s hospitals participating in these offerings. If your hospital has not been participating and would like to, please contact SC Partnership for Health Care Transition Improvement Advisor Laura Cole, RN, MSN at lcole@scha.org or 803.454.6968.

WHY SIGN UP FOR PART IF WE’RE ALREADY IN THE HEN?
While the goals of PART and the HEN are aligned, PART provides hospitals free resources and tools from the nationally recognized care transitions program called BOOST, a national initiative of the Society of Hospital Medicine. If your hospital bought these materials directly from BOOST, you would pay thousands of dollars. But the Partnership for Health is pleased to be making them available to you for free.

A strong focus on care transitions with supporting tools and resources will help you improve the quality of care delivered in your facility. As a result your readmissions will decrease. This is also important because CMS will soon begin to limit hospital reimbursement for avoidable readmissions.

Plus, if your hospital participates in PART, it will receive full credit for participating in the HEN program related to readmission reduction.
HOW DOES MY HOSPITAL SIGN ON?
Your hospital should have received a Data Use Agreement (DUA) to be signed by the appropriate leadership designee and returned to Mary Stargel at mstargel@scha.org. This DUA will give you access to all BOOST materials so your hospital can take full advantage of the PART program and support.

WILL I HAVE TO SUBMIT DATA TO BOTH THE HEN AND PART?
Both programs require data submission. However, when you sign the DUA with SC PfH, you will be giving them permission to pull your hospitals’ data from existing sources. Then that information can be shared with both the state and national programs to track how well South Carolina hospitals are doing at reducing readmissions. It should require minimal work by your staff. Your data will be confidential and used to track the progress of our South Carolina hospitals.

WHAT IF I CAN’T FIND MY DATA USE AGREEMENT?
If you have not received your DUA, please contact Mary Stargel at mstargel@scha.org to request a copy. As soon as we have your signed agreement, you will have access to multiple resources and tools to help reduce your readmissions.
PART GOALS AND OBJECTIVES

The goal of the PART care transitions collaborative is to improve transitions of care across South Carolina and to reduce avoidable readmission rates for patients with Acute Myocardial Infarction (AMI), Congestive Heart Failure (CHF), Pneumonia (PNEU), and Chronic Obstructive Pulmonary Disease (COPD) by 20% by 2014. This would equate to preventing approximately 1,700 hospitalizations per year in South Carolina.

THE PART COLLABORATIVE WILL:

- Support hospitals and communities to create a process map around discharge activity and identify potential barriers and areas of improvement
- Implement evidence-based best practices to identify and correct gaps in the discharge process
- Provide national and state expertise as well as support, resources, and education to hospital staff and community partners as they work collaboratively to create their own customized care transition plan
- Provide a place for hospitals and communities to connect and develop transition strategies appropriate for their needs

This will be accomplished by providing statewide and regional learning opportunities designed to connect community partners and develop action plans. Monthly webinars and coaching calls will highlight exemplar hospitals and communities, host subject matter experts, and allow informal time to discuss successes and opportunities for improvement among peers. The PART program will also provide data collection through the Society of Hospital Medicine (SHM) data entry system, which will allow hospitals to track key process and outcome measures.

SC PfH has also contracted with SHM’s program Project BOOST and the Care Transitions Intervention, developed by University of Colorado Professor of Medicine Eric Coleman, MD to provide educational tools and resources. You also have access to a team of care transitions experts.

The PART initiative is projected to be a two year commitment. If you have questions or would like to participate, please contact SC Partnership for Health Care Transition Improvement Advisor Laura Cole, RN, MSN at lcole@scha.org or 803.454.6968.
PART OVERVIEW

Care transitions have been defined as the movements patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness. The transition from the hospital to the next level of care is problematic and a critical time when patients are at high risk for adverse events. These include new or worsening symptoms, nosocomial infections, and medication-related errors which can lead to recurrent emergency department visits and/or hospital readmissions. Patients with certain chronic diseases such as, CHF or COPD and patients with certain acute illnesses such as AMI and pneumonia are at particularly high risk for bad outcomes. For example, it has been estimated that 1 in 5 hospitalizations for CHF and 1 in 12 hospitalizations for COPD might have been prevented with higher quality care and/or better preparation for discharge during an initial hospital stay.

A recent report from the Dartmouth Atlas outlines an ongoing need for efforts to improve care transitions and reduce hospital readmission rates. Almost one quarter (i.e., 23.8%) of Medicare patients with CHF were seen in an emergency department within 14 days of hospital discharge, and 20.7% were readmitted within 30 days of hospital discharge. Emergency department visits and hospital readmission rates were similarly high for patients with AMI, pneumonia, and COPD. Unfortunately, this study found little change in hospital readmission rates in 2009 compared to rates from 5 years prior. While there is no magic bullet for reducing hospital readmission rates, there is a developing body of evidence documenting best practices that all hospitals can implement. Several states have already organized broad-based quality improvement collaboratives to address care transitions issues, and these are leading to positive changes in processes of care and hospital readmission rates.

Hospitals and other health care organizations are increasingly subject to regulatory and fiscal pressures to improve care transitions. For example, the Centers for Medicare and Medicaid Services (CMS) now publicly reports “risk-adjusted all-cause 30-day hospital readmission rates” for Medicare patients treated for pneumonia, AMI, and HF, and low-performing hospitals will begin to see lower reimbursements starting in 2013. The Medicare Payment Advisory Committee has recommended bundling of payments across the continuum of care surrounding episodes of acute illness. This will lead to reimbursement scenarios that must be divided among all care givers. There are also evolving incentives for health systems to reorganize themselves as accountable care organizations (ACO) or as community-based organizations that are leaders in care transitions.

PART CAN HELP

Recognizing the rising scrutiny of care transitions and the strong desire on the part of South Carolina hospitals to improve, SC PfH and CCME have teamed up to develop the Preventing Avoidable Readmissions Together (PART) initiative. This initiative aims to promote best practices in care transitions, to facilitate discussions among providers and communities, to track statewide progress, and to act as a resource to your organization as you engage in care transitions quality improvement.

We were excited to kick off the two-year PART collaborative in September, 2012. At this meeting, we heard from two leaders in the field of hospital quality improvement, Eric Coleman, MD and Mark Williams,
MD. Participating hospitals were encouraged to assemble a multidisciplinary care transitions team, and attendees were introduced to the concepts of root cause analysis and process mapping to facilitate planning for local quality improvement initiatives. After developing a general process map of the discharge process at participating hospitals, each phase of the PART program will allow teams to “drill down” to the specific parts of the hospital discharge process that need improvement.

**Target Conditions (CHF, AMI, Pneumonia, COPD)**

**PROGRAM COMPONENTS**

In addition to the specific projects described above, this diagnostic process will enable teams to identify other targets for intervention and see the three (3) phases of the PART program.

**Figure 1** provides an overview of each phase of the PART program as currently planned. The program will address two overarching themes throughout its course. First, we intend to target the key diagnoses (CHF, AMI, pneumonia, and COPD), as these are all high-risk conditions for morbidity and readmission and are the subject of current and developing federal reporting and regulatory initiatives. Second, we intend to emphasize community engagement in each phase of the program because care transitions do not take place in a vacuum. It truly takes a village, or a fully engaged community — hospitals, primary care practices, specialty practices, long-term care facilities, pharmacies — and many other partners to improve health and health care for South Carolinians. Each phase of the project will feature educational content and coaching on a different care transitions-related topic and hospitals will be given tools to perform a specific quality improvement project.

In **Phase 1**, hospitals are learning about patient education and preparation for discharge, and they are beginning to implement high-quality transition records. In **Phase 2**, participants will focus on generating
timely and high-quality discharge summaries to facilitate better communication between inpatient and outpatient and next level of care providers. In **Phase 3**, hospitals will focus on strategies to contact patients after they are discharged from the hospital in order to bridge the gap between inpatient and the next level of care. Finally, we know that every hospital will move at its own pace, so we’ve built time into the program in Phase 4 to allow hospitals to continue the implementation projects they started in Phases 1-3 and to plan for sustaining their successes in the future.

To facilitate your work, the PART program is offering the tools and resources of the BOOST online community and data tracking portal. This service would normally cost each individual hospital thousands of dollars, but as part of the collaborative you will have free access. Your team will also have access to the Care Transitions Improvement Advisor, Laura Cole RN, MSN and Physician Lead, Neal Axon, MD, MSCR. We are excited to assist your team in developing a care transitions action plan and to provide individualized coaching along the way. In order for your facility to track progress and access benchmarking data, we are working with the South Carolina Office of Research and Statistics (ORS) to provide you with hospital specific outcomes data on a quarterly basis. We are also using the Project BOOST portal to allow your team to input and track key process measures along the way. This flexible platform will allow your facility to enter other types of data of interest to you in order to meet the needs of your specific program.

With the SC PfH first endeavor, the PART initiative is focusing on reducing avoidable readmissions within the walls of hospitals. CCME is complementing the effort by working with hospitals and communities as a whole. With the hospital at the center, the goal is to promote seamless transitions from the hospital to home, skilled nursing care, or home health care. CCME is providing technical assistance to hospitals and communities by:

- Sharing materials to use as models for community coalition formation
- Providing consultative support for convening a community coalition, which may include social network analysis
- Providing support to create an initial strategic plan for organization, intervention, monitoring, and decision-making that articulates how the community proposed to achieve identified care transition aims
HOW TO USE THIS GUIDE

We are excited that your hospital has made a commitment to improving the quality of care transitions for your patients. However, it isn’t always clear how to get started or how to stay on track when implementing new quality initiatives. That is why we have developed this PART Resource Guide, which is intended to serve two primary purposes. First, this document will provide you and your team with an overview of the PART collaborative. This information should be useful to your team and key stakeholders at your facility. In addition to your patients, stakeholders include front-line health care providers such as doctors, nurses, social workers, and pharmacists, the quality and patient safety staff, your performance improvement team, as well as hospital executives who can provide your team with resources to successfully complete your work.

Second, this guide should provide a useful reference at each step of the program. For instance, it will be useful to review some of the evidence from the medical literature that supports each intervention.

This guide also outlines the anticipated steps for each of the three quality improvement initiatives addressed through PART, the transition record and patient education, improving the discharge summary in both timeliness and quality, and contacting patients after hospital discharge. There are several very useful tools and documents included as appendices to help advertise the program, communicate with patients, collect performance data and track outcomes.

As described previously, PART has enlisted the help of the Society of Hospital Medicine, the organization behind the highly successful Project BOOST. Whenever you see this icon, look for a tip directing you to additional Project BOOST-related resources. These include the Project BOOST implementation guide provided to your team. This 112-page guide offers a wealth of information on general quality improvement and specific tools to improve care transitions.

Whenever you see this icon, look for helpful links for more in-depth content from other sources including the PART website.

Along the way, we’ve added real-world stories from hospitals in South Carolina that have already had success in improving an aspect of hospital care transitions in their community. These stories provide inspiration and remind you that you too, can succeed.
PART APPROACH TO QUALITY IMPROVEMENT

Just as every patient has unique abilities and needs, we recognize that every hospital has unique circumstances and differing levels of quality improvement experience. Your hospital may already be engaged in an organized program of quality improvement to reduce hospital readmissions, such as Project BOOST, the Care Transitions Program, or Project RED, or this may be your first effort. Similarly, you may have a cadre of Six Sigma Black Belts to guide your project team, or your team may lack formal training. The South Carolina Partnership for Health and our partners have attempted to design a program that will be accessible to and useful for all participants, regardless of your quality improvement (QI) experiences to date.

A useful framework for visualizing the steps of any quality improvement process can be borrowed from the Six Sigma methodology. It is a five (5) step process called the DMAIC improvement cycle, and we will use this cycle to illustrate how PART can help your team to succeed at each stage (Figure 2).

DEFINE
The first step in the DMAIC cycle is the “Define” step. During this step, a project team is chartered to improve the efficiency and effectiveness of a given process. In this case, your statement of purpose might read, “Patients with high-risk conditions such as HF, AMI, Pneumonia, and COPD hospitalized at our facility have unacceptably high rates of unplanned hospital readmissions.” Your hospital may have already started this important step by forming a care transitions quality improvement team. PART also offers important assistance during this step by helping your team develop a general process map of the hospital discharge process at your facility.

MEASURE
During the “Measurement” step, QI teams determine their baseline level of performance for a given process or outcome. PART has worked very closely with our leadership and steering committee to devise a series of relevant metrics with which to measure your performance that includes both process measures and outcome measures (See PART Data Collection section on page 29). This includes the acquisition of hospital readmission data for your hospital and for all participating hospitals from the South Carolina Office of Research and Statistics. It also includes a user-friendly and customizable data entry portal provide by Project BOOST and the Society of Hospital Medicine.

Figure 2: Traditional DMAIC framework as applied in Six Sigma methodology.

For additional information on how to generate a process map, check out the lecture on process mapping provided by Dr. Mark Williams and a follow up webinar by Dr. Neal Axon and Dr. Ashley Kay Childers on the PART website at www.scha.org/PART. The section entitled “Getting Started – The Diagnosis Phase” of this resource guide also details how to create a process map.
ANALYZE
The “Analysis” step is often the most important step in the improvement cycle. This is when your team will examine data to determine the causes of poor performance. PART has provided several valuable resources to assist your team during this step. First, working with our partners at CCME, we will share tools for performing a community-based root cause analysis that can help explain the data trends you observe at your facility. Second, to assist your hospital in identifying additional targets for QI intervention, PART will make Ashley Kay Childers, PhD, an Industrial Engineer and QI expert, available to review the process map that your team develops. Dr. Childers’ team of engineering students at Clemson University will help with this process. The PART Listserv is a valuable way to ask questions of your peers in South Carolina as well. Finally, you are welcome to request individual consultations with Laura Cole, RN, MSN, the PART Care Transitions Improvement Advisor or Neal Axon, MD, the PART Physician Lead on an ad hoc basis.

IMPROVE
After the important planning work is accomplished, the “Improve” step is when a series of carefully selected strategies are implemented to improve a process. PART has attempted to identify evidence-based best practices for which there is likely room for improvement at each of the participating hospitals. These include the three PART program phases for improvement: 1) improved patient education and the use of high-quality transition records, 2) improved timeliness and quality of hospital discharge summaries, and 3) implementing strategies for post-discharge patient contact, such as telephone calls. You will likely find additional processes that require improvement as your hospital prepares patients for hospital discharge. In fact, most successful care transitions QI programs to date have used multiple tactics simultaneously to improve hospital readmission rates. Over the course of the two-year initiative, PART will offer information and learning opportunities about a number of other possible interventions that may fit your needs.

CONTROL
The “Control” step focuses on assuring that the process improvements your team makes are sustainable. In some ways, this is the most difficult part of quality improvement. However, PART can help to make sure that once you implement the planned process changes, you can track your successes over time using run charts and benchmarking.
GETTING STARTED — THE DIAGNOSIS PHASE
Understanding a process is the first step toward improving that process. Tools such as process maps, root causes analysis, SWOT diagrams (strengths, weaknesses, opportunities, and threats), and gap analyses can help you to better understand your current system and its needs. Each of these tools is different and has different inputs and outputs, but the idea is the same: what does the current process look like, and where are opportunities for improvement? In this section, we discuss two (2) tools that the PART program recommends to help you and your teams better understand your care transitions processes: process maps and root cause analysis (RCA).

PROCESS MAPPING
A process map is a tool that uses flow chart symbols to graphically depict the steps and sequence of events in a process. Process maps can be used to help you better understand the current state of the system, the desired future state, or the ideal state of the system. Mapping the discharge process from the hospital to the next level of care can help provide a foundation and drive your participation in the PART program as you identify ways to best improve your care transitions processes.

Mapping the sequence of events – in this case how a patient or information moves through the discharge process – can help you and your team identify areas of opportunity associated with bottlenecks, redundancies, delays, or non-value added steps. Non-value added steps are those steps in a process that do not add any value to your patients’ care or are not required by law or the standards of care. Delays and over-processing, such as waiting for a patient transporter or redundant lab tests, are examples of non-value added activities. A value-added step is one that is necessary to deliver care to the patients. These are steps that must be included in our system, and it is our job to determine how to best include these steps so that value-added activities fit and flow as best they can. This is a benefit of process mapping.

Another major benefit of creating a visual representation of a process is to ensure that everyone on the team has a shared understanding about the processes and the sequence of events that occur. There are so many different provider types involved in a patient’s care and preparation for discharge, and a process map is a good tool to help identify “process ownership” through a shared understanding of who is responsible for each step in the process.

BEFORE GETTING STARTED
There are a few things that you can do before you actually start creating a process map that will make the exercise easier. First, identify the process stakeholders. These are people who can be affected by the process as well as anyone who directly or indirectly contributes to the flow of the system. From these stakeholders, it is important to get a good representation to the table to help you create the map. Care transitions processes are very complex, so there are a number of people who may have information that will be helpful in creating a process map. This includes different provider types (e.g., nurses, physicians, and representatives from pharmacy, case management, physical and occupational therapy, etc.) and may even include senior leaders and the patients themselves. You will want to determine the best group of people to help you get a good and meaningful representation of the current process.
Finally, it is important that you observe the process. Even if you are very involved in your organization’s care transitions program, it is important that you observe the entire sequence of events. Often what is actually happening is different from what you think is happening or what is supposed to be happening, so it is best to map the current state of the system based on observations.

**CREATING A PROCESS MAP**

The PART team recommends that you start by creating a high-level process map of your program. Then, drill down on the processes related to specific components of the PART program, and create more detailed process maps (Figure 3, Page 16)

These components include discharge instructions, patient education, quality and timeliness of discharge summaries, and follow-up with patients including follow-up appointments and post-discharge contact. Keep in mind that throughout the PART program, we are focusing on specific conditions (AMI, HF, pneumonia, and COPD) while also considering how community engagement influences the processes. Once you have a team together, the following steps can help you to create both the high-level process map as well PART phase-specific maps.

1. **DETERMINE BOUNDARIES.** Where does your process stop and start? If you were to map the process from the patients’ perspective, it is likely that these boundaries extend beyond admission and discharge, but it is best to set the boundaries for your map based on what your organization can control. Therefore, patient admission and either discharge or some finite point after discharge may be the best initial and terminating points to use for your process map.

2. **LIST THE STEPS IN THE PROCESS.** Have everyone brainstorm each of the steps in the process individually. Instead of focusing on the sequence of events, brainstorm each individual step that occurs. It’s helpful to use sticky notes where one note represents one step in the process.

3. **WORK AS A GROUP TO AGREE ON THE MAP.** You’ll find that everyone’s opinion of the steps in the process is a little bit different. Work as a team to arrange the sticky notes according to the sequence of events. Combine the sticky notes on a wall or a table. If you leave something out or need to reorder the sequence, move the sticky notes around. As a group, agree on the appropriate level or detail, proper wording, and flow chart symbols.

4. **TRANSFER AND SHARE YOUR DRAFT.** Once your team agrees on a map, transfer it to a document that you can share with others to get their feedback.

5. **REFINE AND ITERATE.** Based on other stakeholders’ feedback, refine until you have a process map that best represents your process.
For the detailed process maps related to the PART components, consider the following questions to help you create your map.

- **DISCHARGE INSTRUCTIONS.** What elements are currently included in your discharge instructions? Where does this information come from, and who is responsible for this information?
- **PATIENT EDUCATION.** Who teaches at your institution? When do they teach? What materials do they use? How is this documented? Are there additional steps for certain patient types (e.g., heart failure, pneumonia, AMI, or COPD)?
- **DISCHARGE SUMMARIES.** What elements are currently included in discharge summaries? How does this information vary? Where does this information come from? When and where is it shared?
- **PATIENT FOLLOW-UP.** What type of plans are made for follow-up care while the patient is in the hospital? Who follows up with the patients post-discharge? When are follow-ups conducted, and what type of information is collected?

**PROCESS MAP SYMBOLS**

Figure 3 illustrates some of the most commonly used process map symbols. They include symbols for terminating points (e.g., a patient is admitted), a process (e.g., a physician generates a discharge order), a decision (e.g., COPD patients may need additional teaching), documentation (e.g., discharge instructions), or a delay (e.g., waiting for patient transport). Depending on the level of detail that you choose for your maps, it may be helpful to differentiate between the types of flows. For example, you may want to use a continuous line for the patient flow and a dashed line to represent the flow of information. Be sure to include a legend explaining the symbols that you use on the map.

There are so many different people who contribute to care transitions processes that it may be helpful to use a swim lane map to add an additional level of detail. In a swim lane map, “lanes” are used to illustrate who is responsible for each step in the process. It can also be used to further identify opportunities for improved work flow. The steps for creating a swim lane map are the same as a process map, but each process is assigned to a lane (Figure 4).
ADDITIONAL HINTS
A process map yields more than just a diagram of a sequence of events. Consider these additional hints.

- **KEEP LISTS.** When you get people together to talk about your process, you will inevitably come up with a list of assumptions and questions that require follow-up. In addition, so much brainstorming and group work may lead to ideas for improvement. While you are not currently mapping these ideas, you will want to keep track of them.

- **CONCENTRATE ON THE PROCESS, NOT THE PEOPLE.** You are trying to map the system and its opportunities for improvement, not the people who use it.

- **DON’T GET OVERWHELMED; MAKE A MAP THAT WORKS FOR YOU AND YOUR TEAM.** Because these are complex systems, the process maps can get complicated. It is important that you do not get bogged down in the details of creating the process map but instead create something that works for you. The notes presented in this section of the PART guide are suggestions. The important thing is to come up with a way to graphically represent the process, so do what works best for you. In addition, everyone at the table may not agree about the current state process may, but you should use this as an opportunity to discuss those inconsistencies and discrepancies and identify areas for opportunity.

- **FINALLY, REMEMBER THAT A FLOWCHART IS A MEANS, NOT AN END**. After you create a process map, use it! Let the map guide discussions with your colleagues about how you can improve care transitions for your patients.

Figure 4: Sample swim lane diagram.
ROOT CAUSE ANALYSIS TOOLS

RCA is another great tool to assess how the care transitions process works in your hospital. Like process mapping, it gives you a good picture of the steps and sequence, but also adds an analysis of failure points. The RCA process is a method of problem solving that tries to identify the root causes of problems that cause operating events, i.e., why a patient and/or a group of patients is at risk for readmission or why certain patients return to the hospital. The RCA practice tries to solve problems by attempting to identify and correct the root causes of problems, as opposed to simply addressing the symptoms or the outcome. By focusing on correction in root causes, readmissions can be prevented, or at least decreased. The PART initiative recommends using RCA to look at why readmissions are taking place and to help find solutions for the concerns that continue. RCA can also be used to forecast or predict probable events even before they occur, a proactive approach to reducing preventable readmissions.

Most hospitals use the RCA process in the Risk Management Department already, and there may be other departments or processes within the hospital that utilize this approach as well. Many nursing units already use RCA to look at specific patient occurrences now, but it is typically not consistently used to examine the readmission process, or in a perspective or proactive way.

The PART Team can help get this resourceful process hard-wired in the participating hospital.

CCME designed data collection tools (e.g., Root Cause Analysis forms available in the Appendices 2-4) for use in acute inpatient, home health and nursing home settings. The tools were designed to standardize the process of data collection, analysis, use, and ultimately, performance evaluation. CCME can also help individualize your approach to assessing your patient transition process and develop RCA tools that are customized to meet your hospital’s needs. In addition to utilizing and developing these tools, each facility should create a standardized data dictionary based on its own internal needs to be used in the elements of the process.
PHASE 1: THE TRANSITION RECORD AND PATIENT EDUCATION

TRANSITION RECORDS
Transition records are documents provided directly to patients at the time of hospital discharge that contain key elements of information related to their hospital stay. These documents are often called discharge instructions or discharge paperwork, and typically include the reason for hospital admission and principle diagnoses at discharge, a current medication list, and multiple elements related to hospital follow-up care. Transition records are invaluable and can facilitate patient education at hospital discharge, empower patients, and improve post-discharge care. To date, almost all randomized trials of multimodal care transitions interventions have included some form of transitional record, so we know that improving the quality and reliability of these documents can contribute to reduced hospital readmissions. 15-20 Experts have generally come to a consensus about key elements of information and optimal formatting approaches for transition records. A high quality document should include the following ten (10) elements.

- Reason for inpatient admission (typically in plain language)
- Principle medical diagnoses at discharge
- Major procedures and tests during hospitalization and a summary of results
- Current medication list after a medication reconciliation procedure
- Studies still pending at discharge
- 24 hour / 7-day per week contact information for the patient to contact the hospital
- Contact information for obtaining results of studies still pending
- Plans for follow up care (the more specific the better)
- Primary physician or other professional or site designated for primary care
- Information on advanced directives and/or patient preferences for end-of-life care (Optional, but is another important element for consideration on all transition records)

The PART team has already put together a mock-up, or template that your hospital may choose to adapt as a transition record at your facility (Appendix 1). Alternatively, you may choose to modify your existing discharge instructions form or develop your own so that it includes all of these valuable elements of information for your patients.
PATIENT EDUCATION

Just as a book that sits unopened on a shelf serves little purpose other than collecting dust, assembling critical information for patients is fruitless unless this information is shared with patients in a meaningful way. Thus, communication and patient education are critical for safe care transitions. That is why PART is dedicating quite a bit of time in our educational offerings to patient education and preparation for hospital discharge. Studies show that a majority of patients leave the hospital with misunderstandings about their diagnoses and medications, and that those who leave feeling better prepared for discharge are less likely to be readmitted\textsuperscript{21, 22}.

Teach Back, one of tools available in the PART program, is an ingeniously simple yet powerful educational tactic that can improve communication and clarify patient misunderstandings in real time as patients prepare for hospital discharge. In collaboration with the Society of Hospital Medicine (SHM), all PART hospitals will receive a copy of the Teach Back instructional video and curriculum produced by the leaders of Project BOOST. We strongly encourage you to implement a Teach Back curriculum to train all staff at your facilities.

TRANSITION RECORD IMPLEMENTATION PROCESS

Though implementation timelines will doubtless vary from one facility to the next, it should be feasible to implement a high quality transition record and new patient education protocol at your hospital over a six-month period. As with any implementation project, it can be broken down into smaller phases or steps. For very large changes such as a new electronic medical record system (EMR), slower unit-by-unit rollouts may have advantages in terms of person power and resources. However, for a single form and/or process, you may decide that “big bang” is the way to go.

After an initial planning phase of one to two months, many facilities opt to pilot their new transition record on a single unit for several weeks in order to iron out any kinks in their new form and process. Then, the new transition record can be “rolled out” to the entire facility either in one fell swoop or by unit.

The pilot phase really represents “beta testing” for the new transition record document and your enhanced patient education process. It is helpful to pick a ward or nursing unit where there is already enthusiasm for such process improvement. Remember, it is not expected that the new form or process will be perfect, so don’t get discouraged or abandon your efforts. Instead, take the time during the pilot
phase to learn the necessary lessons that will ensure a successful large-scale rollout. Soon, it will be time to disseminate your new form and process to a wider audience.

Key objectives in the planning phase are:

- Identifying champions in management and process owners among front-line personnel
- Completing a detailed map of the current patient education process
- Collecting information on baseline performance to identify gaps in the current process
- Securing proper approvals to change forms and processes

MAINTAINING AND EXTENDING THE TRANSITION DOCUMENTS

As your new transition record gets up and running, it will be critical to determine if the implementation process is working. Evaluating how things are going by looking at a few key areas is beneficial for success.

You can ask several questions, (i.e.):

- Check and see how often the new forms are being used?
- Which data elements, if any, are routinely missing from completed forms?
- How well are nurses and other providers documenting the use of Teach Back?

These are all useful data elements to monitor. This is where chart abstraction and review and the use of the PART or BOOST data website can be invaluable.
PHASE 2: IMPROVING DISCHARGE SUMMARY TIMELINESS AND QUALITY

The hospital discharge summary is a key part of the medical record meant to facilitate communication between inpatient and outpatient providers and the patient with the potential to reduce risk for problematic care transitions. Regrettably, discharge summaries are often deficient in both their timeliness and their quality\textsuperscript{23-25}. A recent systematic review found discharge summaries were available at the time of first hospital follow up only 12-34\% of the time, and key summary elements such as the hospital course, diagnostic test results, and discharge medications were often omitted\textsuperscript{26}. In particular, summary elements related to care transitions such as to follow up appointments, tests pending at the time of discharge, and patient care instructions were often missing\textsuperscript{24-25}. Doctors and other providers receive little formal training in how to produce a high-quality discharge summary, and many trainees perceive the need for better education in this area\textsuperscript{27}. For these reasons, and based on input from the PART Leadership Team, we will focus on standardizing and improving discharge summaries during Phase 2 of the PART program. The ultimate goal is to generate high-quality discharge summary documents for patients discharged from your hospital that will be available to primary care providers and/or the next level of care, in their settings by the first patient follow-up, usually within one to two weeks after hospitalization.

PLANNING

In preparing to address discharge summary timeliness and quality, your team should return to the general process map that your team developed earlier. Now is the time to “drill down” and develop a more detailed flow diagram for the generation of discharge summaries. Processes will doubtless vary from one hospital to the next, and occasionally among physician groups in a given hospital. Figure 5 illustrates several of the common steps where breakdowns might occur. For example, providers may fail to dictate discharge summaries prior to hospital discharge. Dictated summaries may not include necessary elements such as a correctly reconciled discharge medication list or a list of tests still pending at the time of discharge. Alternatively, there may be delays in transcribing summaries, obtaining signatures to finalize summary documents, or forwarding documents to primary care and other post discharge providers.

\textbf{Figure 5:} Example of a process map for discharge summary generation.

\textbf{Often, just a few thorough chart reviews can help your hospital establish a baseline for performance and determine where gaps exist.}
APPROACHES TO IMPROVE DISCHARGE SUMMARIES

Fortunately, there are many effective strategies in this area. For example, the use of a “template” card, or outline, while dictating summaries has been shown to improve discharge summary content (Appendix 7)\(^28\). Providing feedback to providers on their performance has also been shown to improve summary quality and timeliness\(^29\). The strategies your team chooses should be based on your process map and preliminary data gathering. In general, it is important to address systems-related factors (i.e., machines, materials, methods, or measurement, IT barriers, EMR limitations, and documentation constraints and requirements) before tackling human behaviors, because the system can be the common cause of poor performance. That said, the process of generating discharge summaries is likely more dependent on the behaviors of physicians and non-physician providers than any other area you will address during your care transitions process. Thus, in addition to fixing systems issues, the strategies your team chooses must facilitate and enable providers to change their behaviors. Here are some successful strategies\(^30-32\).

- **PROVIDER EDUCATION**: Studies show that educational initiatives are the most common means for attempting provider behavior change. Though education alone is rarely sufficient to mediate change, it is a necessary component of any program meant to introduce and publicize your team’s work. PART will offer useful materials for your hospital, including sample press releases and promotional posters.

- **OPINION AND THOUGHT LEADERS AND CHAMPIONS**: Especially in community settings, the use of local opinion and thought leaders has been shown to be an effective strategy to influence provider behavior. For this reason, it is critical that your team include physician representatives, ideally from both the inpatient setting (e.g., hospitalists) and outpatient setting (e.g., primary care providers) who can act as champions. These individuals can lobby executive leaders for resources, advise your team, and even provide ‘detailing’ to other physicians, similar to what pharmaceutical representatives do to communicate product information\(^33\).

- **AUDIT AND FEEDBACK**: Whether provided to individuals or to groups, audit and feedback is one of the most common and effective ways to promote practice change\(^34\). PART has developed easy-to-use chart abstraction tools and a user-friendly data portal (see the section on Data Collection on page 28) that will enable your team to use this valuable strategy. This data will also be useful as you track program success.

- **PROMPTS AND DECISION AIDS**: As described above, providers who were given a discharge summary template card were more likely to include key pieces of information in their discharge summaries. Thus, PART has developed a sample template card that you may choose to use at your hospital (Appendix 7).

- **INCENTIVES**: Finally, incentives offer some of the most useful tools for facilitating practice change in health care settings. Inducements or incentives may provide either positive (i.e., a “carrot”) or negative (i.e., a “stick”) reinforcement, and successful programs often use a judicious mix of both. Thus, your hospital may choose to incentivize good performance on discharge summaries by linking
performance to bonus pay or by publicizing the efforts of top performers. Alternatively, your medical executive committee (MEC) may choose to change discharge summary policies as the time limit for completion decreases from The Joint Commission-mandated 30-day window to a more clinically relevant two to three day window. Negative reinforcement strategies can range from a personal meeting or email from your hospital’s chief medical officer to restrictions on hospital privileges for repeating performance outliers. Most providers will respond well to such constructive criticism when it is framed around the shared goal of improving patient care and quality. Hospital policy changes can usually be done in stages to allow acclimation. With such an infrastructure in place, it becomes easier to regulate the timeliness of discharge summary completion.

**TIMELINE:** Over a six-month implementation period, it should be feasible for your team to complete an in-depth map of your discharge summary process, collect preliminary data, and begin monthly chart abstractions for process measure data, about thirty (30) per month. You can then begin to implement the strategies described above with the help of your physician champions.
PHASE 3: CONTACTING PATIENTS AFTER HOSPITAL DISCHARGE

The vast majority of interventions to reduce hospital readmissions feature some form of contact with the patient after leaving the hospital, such as post-discharge telephone calls, home visits, or both\textsuperscript{35}. Post-discharge telephone calls have been shown in individual studies to be associated with lower hospital readmission rates\textsuperscript{36}, lower emergency department (ED) visit rates\textsuperscript{37}, better attendance at primary care follow up\textsuperscript{18}, and higher patient satisfaction.\textsuperscript{37} Home visits, though cost and labor intensive, are one of the most consistently effective strategies to reduce hospital readmissions based on available studies\textsuperscript{15,38}. In addition, documentation of post-discharge contact has been proposed by some health care agencies as a process of care quality measure\textsuperscript{9}. For these reasons, we strongly encourage your PART team to implement some form of post-discharge contact as a component of your care transitions quality improvement plan.

Many hospitals have already initiated some form of post-discharge telephone calls, and we expect that most will choose this form of post-discharge contact. Telephone calls can achieve several important objectives for patients (Figure 6). First, they represent an educational opportunity to reinforce lessons learned in the hospital. Second, telephone calls allow providers to identify problems that arise from new or worsening symptoms, medication acquisition and adherence, and compliance with follow-up visits. Third, many hospitals find that these calls are a rich source of information which can be used to identify gaps in performance. Patient observations can be collected in the form of standardized questionnaires or as free-text feedback.

Figure 6: Common evolution of discharge telephone call programs.
Post-discharge telephone calls can also be used to improve patient satisfaction scores, and many hospitals began their telephone call programs for this purpose. While most patients appreciate receiving a call after discharge, these calls can and should be used for more advanced patient assessment as described above. Ideally, telephone call programs are structured to enable closed loop communication that links patients with problems to their hospital or primary care providers. This type of program can enable safe outpatient management where possible and prevent hospital readmissions. Finally, successful programs also ensure sustainability and ongoing effectiveness through well-defined metrics and monitoring. Whether you’re just beginning a program for post-discharge telephone calls or are already well on your way, PART can provide your team with tools and advice to move to the next level.

PLANNING
As you plan a post-discharge telephone program, it will be important for your team to review some baseline data on your hospital discharges and information from your general discharge process map. For example, how many discharges does your hospital have per month, especially for high-risk conditions such as HF, AMI, pneumonia, and COPD? This may affect the scope of what your team can accomplish. Who is best positioned to make telephone calls? Depending on your discharge process, one team member or group may be an obvious choice. What kinds of problems were uncovered in your root cause analysis that telephone calls may help to address? For example, many hospitals find that telephone calls can be used to mitigate discrepancies in medication reconciliation.

APPROACH
There are several issues to consider in planning a program for post-discharge contact with patients. For example,

• WHO WILL MAKE THE POST-DISCHARGE TELEPHONE CALLS?
  Different programs choose different team members, and nurses, case managers, pharmacists, and even physicians have been reported to participate. To some degree, the selection of team members will depend on how many calls need to be made. Most hospitals use nurses or pharmacists participating in patient care, but some organizations have developed centralized call centers to streamline the call process.

• FROM WHERE SHOULD CALLS BE MADE?
  Most post-discharge call programs are hospital-initiated. However, there are also good examples of primary care based programs. If your facility is a part of an integrated health system, this latter approach may be optimal.

• WHEN AND HOW MANY CALLS SHOULD BE MADE?
  Because most hospital readmissions occur within the first three days after discharge, it is important to try to reach patients during this time window.

• WHICH QUESTIONS SHOULD CALLERS POSE TO PATIENTS?
  Ideally, questions should address the following issues:
  o Symptoms
  o Focused patient education
• **WHAT SHOULD BE DONE ONCE PROBLEMS ARE IDENTIFIED?**
  Many questions that arise can be answered by a trained nurse or other provider who has access to the patient’s medical record and, ideally, a copy of the transition record and other materials given to the patient at the time of discharge. It is also important to develop a system for identifying and contacting a responsible provider.

• **WHAT METRICS SHOULD OUR TEAM MONITOR REGARDING TELEPHONE CALLS?**
  Here are some suggestions:
  - Proportion of calls attempted and completed over the total number indicated
  - Descriptive information on issues arising in calls
  - Categorical data
  - Qualitative data
  - Validated surveys
  - CTM-3
  - Patient knowledge of heart failure
  - Others

**TIMELINE**
The timeline for implementing post-discharge telephone call programs will vary, especially depending on whether or not a program is already in place. However, a reasonable goal should be to complete the planning and to begin a pilot program within six months. For hospitals that have existing programs, planning should focus on how to expand or improve, with appropriate goals over a similar timeframe.
CUSTOMIZING YOUR CARE TRANSITIONS PROGRAM

The transition from hospital to home or another level of care is a challenging time for patients recovering from acute illness and their families, and it has been argued that patients experience a period of generalized increased risk for complications right after hospitalization\textsuperscript{40}. Experience in care transitions quality improvement teaches two valuable lessons. First, many of the evidence-based best-practice strategies for reducing hospital readmissions are helpful, but not powerful enough alone to stimulate change. Multiple simultaneous strategies must be employed. Second, because of differences in organizations and patient populations, the choice of strategies will and should vary from one hospital to another. That is why, in addition to the approaches we advocate as core components of the PART program, we encourage your team to select and implement additional strategies based on your RCA and process mapping exercises that are customized for your organization.

PRE-DISCHARGE INTERVENTIONS

- Readmission risk screening
- **Patient education**\textsuperscript{*}
- Discharge planning
- Medication reconciliation
- Appointment scheduled before discharge

POST-DISCHARGE INTERVENTIONS

- **Timely follow-up**\textsuperscript{*}
- Timely communication with primary care providers
- **Follow-up telephone call**\textsuperscript{*}
- Patient hotline
- Home visits
- **Timely and complete discharge summaries**\textsuperscript{*}

BRIDGING INTERVENTIONS

- Transition coaches / Patient navigators
- **Patient-centered discharge instructions**\textsuperscript{*}
- Provider continuity
- Hospital-based post-discharge clinics

\textsuperscript{*}Elements stressed in the PART initiative
PART DATA COLLECTION

BOOST DATA WEBSITE AND DATA CENTER
As a participant in the PART initiative, you have the benefit of accessing the SHM’s Project BOOST Website & Data Center for Performance Tracking. The website is your gateway to all of the resources needed in the collaborative. It will allow you to:

- View program announcements & events
- Access the BOOST toolkit
- Upload and view shared tools & resources with other participating sites
- View regional cohort schedules and contact lists
- Network & post discussions via listserv; view past archives discussions
- View on-demand and live webinars
- Link to your private (password-protected) hospital-specific data centers to upload and benchmark data, run reports, view mentor call logs, track milestones and upload private documents among your team members.

PROJECT BOOST WEBSITE LOGIN
Login information to access this website and resources are available to you, once your signed DUA is received.

The new Project BOOST website is http://connect.hospitalmedicine.org/BOOST. You may want to bookmark this to your internet browser.

1. **PROJECT BOOST PASSWORDS:** Project BOOST will provide participants with community website usernames and passwords. Please contact Lauren O’Sullivan losullivan@hospitalmedicine.org if your primary contact has not received this information. Your contact will be given access to the BOOST site and tools.

2. **BOOST WEBINAR:** There will be introductory webinars in the near future. Please contact Laura Cole if your hospital would like to attend so we can ensure that you receive a password to the BOOST site.

DATA CENTER LOGIN
Once you log into the website, there will be a tab on the top navigation titled “Data Center”. In order to access the data center portion of the website, you will need to re-enter your BOOST login information. The second login is a security check as you enter your individual hospital’s data center where you will be able to upload and benchmark data, view your mentoring call logs, track performance through milestones, and upload confidential documents to share with your team. This data center is only accessible by the members of your hospital team and cannot be viewed by the entire collaborative.

IMPORTANT NOTE
The two systems (website and data center) do not connect. Therefore, if you change your password in the
data center, please be sure to change it for the website as well. If you would prefer to keep the two passwords separate, you may choose to do so by resetting your passwords in each system. If you need any assistance, please feel free to contact Lauren O’Sullivan at BOOST at losullivan@hospitalmedicine.org or 267.702.2672.

PROCESS MEASURE COLLECTION
Providers are asked to complete the patient transition record measure and collect 30 charts monthly. Patient topics include heart failure, heart attack, pneumonia and chronic obstructive pulmonary disease. A sample chart takes approximately three minutes to complete.

PATIENTS TRANSITION RECORD DATA ABSTRACTION TOOL
A patient transition record tool is provided on the BOOST website. Providers can directly abstract charts 1) from the BOOST website or 2) upload their data information using an excel data abstraction form. Directly click the box next to the data element that is provided in the patient’s record. If all elements are documented in the patient transition record, click the box that reads “patient care transition record has all elements.” Each measure element on the patient transition record has an associated abstraction guide.

GENERAL DATA ELEMENTS

• PATIENT IDENTIFIER: Enter patient’s identifier number for the hospital admission being abstracted.

• DISCHARGE DATE: Enter patient’s discharge date for episode being abstracted using mm/dd/yyyy format.

• TRANSITION RECORD PROVIDED TO PATIENTS AT DISCHARGE: Documentation information does not have to be titled “transition record.”
  o Examples of other document names are discharge instructions, education and follow up.

• REASON FOR INPATIENT ADMISSION (PLAIN LANGUAGE): Documentation of the reason for inpatient admission.
  o Examples: chest pain, stroke, fracture

• PRINCIPAL DIAGNOSIS AT DISCHARGE (MEDICAL LANGUAGE): Documentation includes at least the patient’s principal diagnosis at discharge.
  o Example: reason for admission - chest pain

• MAJOR PROCEDURES AND TEST PERFORMED DURING INPATIENT STAYS AND SUMMARY OF RESULTS: Documentation of major procedures and results. Procedure would be classified as a surgical or intervention procedure.
  o Examples: Total hip replacement, cardiac catheterization and stent were placed.

• DISCHARGE MEDICATION LIST: Documentation provided to patient includes a list of their discharge medications. The list should contain the patients’ current medications.
• **STUDIES PENDING AT DISCHARGE:** Documentation of any major lab tests, radiology, pathology etc., results pending at discharge
  
  o Example: Chest ray results pending

• **EMERGENCY CONTACT INFORMATION (PHYSICIAN):** Documentation provides 24-hour/7 day contact information for emergencies related to this admission.
  
  o Example: Call 911

• **CONTACT INFORMATION (TEST RESULTS FOR OBTAINING RESULTS OF STUDIES PENDING AT DISCHARGE):** Information on how to follow-up to receive final results.
  
  o Example: Chest x-ray results to be reviewed with Dr. Smith

• **PLANS FOR FOLLOW-UP:** Documentation for patient of a plan for follow-up care.
  
  o Example: Patient to call Dr. Smith and schedule appointment for next week of 5 day from now

• **PRIMARY PHYSICIAN, OTHER HEALTH CARE PROFESSIONALS OR SITE DESIGNATED FOR FOLLOW UP CARE:** Documentation includes at least the name and phone number of primary care doctor or health care professionals

The BOOST website has elements other than the patient transition record measure that your team can directly upload and utilize. We are not requiring these items, but would be happy to work with hospitals that are interested in utilizing them.

**PLEASE NOTE**
The Care Transition Record measure will be uploaded in the Premier data portal for providers participating in Partnership for Patients.

**OUTCOME MEASURE COLLECTION**
The SC Office of Research and Statistics (ORS) is providing the outcomes data to all hospitals with a signed data usage agreement. The data will be uploaded to the BOOST website by Aunyika Moonan, PhD, Director of Quality Measurement Services, SCHA, who works closely with ORS. The data are secure and confidential, and no patient identifiers will be displayed. Each hospital will have access to their data and only aggregate information will be used for benchmarking. The SC PfH and the PART team will be able to see hospital-specific data, but this will only be utilized internally, to facilitate the program goals.

The data variables on the BOOST website include statewide and blinded individual all cause readmission data rates to any hospital or back to the same hospital in South Carolina. Specific readmission data for AMI, HF, Pneumonia, COPD and readmission to the ED or observational setting at any hospitals within 30 days of discharge from the inpatient setting will be emailed to the hospitals on a quarterly basis. Furthermore, we will email Medicare 30-day rate performance trends and readmission financial impact summary data to individual hospitals when an update is provided.
Research DUA: The research DUA will specifically allow your de-identified data in aggregate with other hospitals to be compared and published. An example of this would be if we had one hospital participating in a specific research project and wanted to compare it to other hospitals in the state. Your information would be utilized in the comparison. (Appendix 12)
REFERENCES


INTERNET RESOURCES

GENERAL QUALITY IMPROVEMENT

- The Institute for Healthcare Improvement (www.ihi.org)
- The American Society for Quality (www.asq.org)
- The Society of Hospital Medicine (SHM) (www.hospitalmedicine.org)
- The Agency for Healthcare Research and Quality (AHRQ) (http://www.ahrq.gov/qual/qualix.htm)

CARE TRANSITIONS QUALITY IMPROVEMENT

- Project BOOST (http://connect.hospitalmedicine.org/HP3) (BOOST member sites)
- Care Transitions Project (http://www.caretransitions.org/)
- Project RED (https://www.bu.edu/fammed/projectred/)
- IHI
- Reducing Readmissions (http://www.ihi.org/explore/Readmissions/Pages/default.aspx)
- STAAR (www.ihi.org/STAAR)
- Hospital 2 Home (H2H) (http://www.h2hquality.org/)
- AHRQ Care Transitions Program Toolkit (http://www.innovations.ahrq.gov/content.aspx?id=147)
- The National Transitions of Care Coalition (www.ntocc.org/)

PATIENT EDUCATION

- The Institute for Patient and Family Centered Care (http://www.ipfcc.org/about/index.html)
- No Time To Teach (http://notimetoteach.com/)
- The Centers for Disease Control and Prevention (CDC) Health Literacy Resources (http://www.cdc.gov/healthliteracy/)
- Medline Plus (http://www.nlm.nih.gov/medlineplus/)
Preventing Avoidable Readmissions Together (PART)

APPENDICES
Appendix 1

Hospital Discharge

Transition Record

<table>
<thead>
<tr>
<th>I was hospitalized at ____________________________ Hospital from ______________________ through ___________________ for the following problems.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(=In Plain words)</td>
</tr>
<tr>
<td>At the time of hospital discharge I have been diagnosed with:</td>
</tr>
<tr>
<td>(=In Medical words)</td>
</tr>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>Other:</td>
</tr>
</tbody>
</table>

| My Medications at the time of hospital discharge include the following.                                         |
| Home medications to be continued…                                                                              |
| 1.                                                                                                               |
| 2.                                                                                                               |
| 3.                                                                                                               |
| 4.                                                                                                               |
| 5.                                                                                                               |
| 6.                                                                                                               |
| 7.                                                                                                               |
| 8.                                                                                                               |
| 9.                                                                                                               |
| 10.                                                                                                              |
| 11.                                                                                                              |
| 12.                                                                                                              |

| New medications to be started after hospital discharge…                                                         |
| 1.                                                                                                               |
| 2.                                                                                                               |
| 3.                                                                                                               |
| 4.                                                                                                               |
| 5.                                                                                                               |
| 6.                                                                                                               |
| 7.                                                                                                               |
| 8.                                                                                                               |

| Home medications to be discontinued… (STOP TAKING THESE!)                                                       |
| 1.                                                                                                               |
| 2.                                                                                                               |
| 3.                                                                                                               |
| 4.                                                                                                               |
| 5.                                                                                                               |
| 6.                                                                                                               |
| 7.                                                                                                               |
| 8.                                                                                                               |

| While in the hospital, I had the following tests and procedures.                                                 |
| 1.                                                                                                               |
| 2.                                                                                                               |
| 3.                                                                                                               |
| 4.                                                                                                               |
| 5.                                                                                                               |
| 6.                                                                                                               |

| If I have the following problems after discharge, I should:                                                   |
| 1.                                                                                                               |
| 2.                                                                                                               |
| 3.                                                                                                               |
| 4.                                                                                                               |
| 5.                                                                                                               |

| The tests and issues I need to talk with my doctor(s) about at my clinic visit are:                           |
| 1.                                                                                                               |
| 2.                                                                                                               |
| 3.                                                                                                               |
| 4.                                                                                                               |
| 5.                                                                                                               |
After hospital discharge, I have the following appointments.

1. ______________________________________
   On __/__/____ at __:__ am/pm.
   For______________________.

2. ______________________________________
   On __/__/____ at __:__ am/pm.
   For______________________.

3. ______________________________________
   On __/__/____ at __:__ am/pm.
   For______________________.

4. ______________________________________
   On __/__/____ at __:__ am/pm.
   For______________________.

_______________________________________________
_______________________________________________

Important Contact Information.

I can call (XXX)XXX-XXX at any time day or night if I have emergent questions. For specific questions, and during daytime hours, I can call the numbers listed below:

Either I or my doctor can call (XXX)XXX-XXXX to obtain these test results after hospital discharge.

1. My primary doctor:
   ______________________________
   (____)________________

2. My hospital doctor:
   ______________________________
   (____)________________

3. My case manager or social worker:
   ______________________________
   (____)________________

4. The hospital nursing unit:
   ______________________________
   (____)________________

5. My visiting nurse:
   ______________________________
   (____)________________

6. My pharmacy:
   ______________________________
   (____)________________

I have discussed my end-of-life care preferences and/or advanced directives with my medical team, and my preferences are as follows.

- In the event that my heart should stop beating or my breathing should fail, I prefer that my medical team allow me to have a natural death (Also known as Do Not Resuscitate status).
- I have completed an advance directive, and this document can be found:
  _______________________________________________________
  _______________________________________________________

- In the event that I am unable to make medical decisions, I would like the following person(s) to make medical decisions for me:
  _______________________________________________________
  _______________________________________________________

  Legally, this person is my health care power of attorney,

Further Instructions:

- _______________________________________________________
- _______________________________________________________
- _______________________________________________________
- _______________________________________________________
- _______________________________________________________
- _______________________________________________________
- _______________________________________________________
- _______________________________________________________
- _______________________________________________________
- _______________________________________________________

I will make sure to keep this document handy when I get home, and I will take it to my follow up clinic appointments to help communicate with my other doctors.
Care Transitions Abstraction Template for Skilled Nursing Facilities

FACILITY

ABSTRACTOR ______________________ DATE OF ABSTRACTION __________

Demographics

1. Patient tracking number: __________________
2. Patient age: __________
3. Discharge date from hospital: __________
4. Hospital LOS: __________
5. Primary discharge diagnosis from hospital. Code: __________
   Description: ____________________________________________
6. How many days was patient in NH before readmission to hospital? __________
7. Was readmission to hospital related to first admission to hospital? Yes No

Transfer Back to Hospital

8. Nurse on duty: ________________________ RN or LPN? __________
9. Date of transfer: __________ Day of week of transfer: __________ Time of day of transfer: __________
10. a. Transfer order by (MD, NP, medical director, PCP, other): __________________________
10. b. Mode of transfer (ambulance, private vehicle): __________________________

Efforts to Handle Without Transfer

11. List patient’s symptoms, which led to rehospitalization: ____________________________________________

11 a. Resident evaluated by physician or advanced practice nurse onsite? Yes No
11 b. Practitioner in-depth telephone discussion? Yes No
11 c. IV/SQ fluids? Yes No
11 d. Lab tests? Yes No
11 e. X-ray? Yes No

919.461.5500 (NC) • 800.682.2650 (NC) • 803.212.7500 (SC) • 800.922.3089 (SC) • www.ccmemedicare.org
Care Transition Readmission Hospital Medical Record Review

REVIEWER ________________________________ DATE ______________

HOSPITAL ________________________________

Initial Admission # ________________________ Readmission # __________

Discharging Physician ____________________

Initial Admission Date ___________ Initial Discharge Date ___________

Readmitted in ______ Days | Readmission Date ______
(Do not count day of discharge/do count admission date)

Planned Readmit?  ☐ Yes  ☐ No  If YES, terminate abstraction and exclude case.

Initial Admission Primary Diagnosis ICD-9-CM code: __________________

English description: ______________________

Initial Admission Secondary Diagnosis ICD-9-CM code: __________________

English description: ______________________

What were the presenting symptoms on the initial admission?

__________________________

__________________________

__________________________

1. Was the patient discharged to the level of care recommended?  ☐ Yes  ☐ No

☐ Home and follow up with Primary Care Physician  ☐ Home with Services  ☐ Long Term Care Facility

☐ Home Health  ☐ Assisted Living  ☐ Rehab Center  ☐ Long Term Care Acute Hospital

☐ Hospice  ☐ Other: ______________________

Comment (recommendations by other disciplines): __________________________

__________________________

__________________________

__________________________

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Care Transitions Readmission Data Form for Home Health Agencies

Home Health Agency: ____________________________ Chart ID: ____________________

Date of Abstraction: ____________________________ Abstructor: ____________________

Hospital Discharge Date: ______________ Start of Care (SOC) Date: ______________

Hospital Readmission Date: ______________ # Days from SOC to Readmission: __________

Was this a planned readmission to hospital? Yes ☐ No ☐
If “yes” stop abstraction and exclude case.

Was patient seen prior to readmission to hospital? Yes ☐ No ☐

How many days between hospital discharge and SOC date? ____________________________

Home Health Primary Diagnosis (from hospital): ____________________________

ICD-9-CM code: ____________________________

Description: ____________________________

Secondary diagnoses: ICD-9-CM code: ____________________________

Description: ____________________________

List patient symptoms/CC at SOC: ____________________________

List patient symptoms at end of care/readmission: ____________________________

Is there evidence of attempt to assess patient for risk of hospitalization? Yes ☐ No ☐

Is patient’s resuscitation status listed in record? Yes ☐ No ☐

List if YES: ____________________________

Was there evidence of an immediate/urgent care plan addressing warning signs and symptoms? Yes ☐ No ☐

At time of SOC, was there a legible hospital discharge instruction sheet in the home? Yes ☐ No ☐
PART: Preventing Avoidable Readmissions Together

January 8, 2013

Dear PART participants,

After months of preparation, we are very pleased to share the long awaited Preventing Avoidable Readmissions Together “PART” Data Use Agreement (DUA). As we move forward, this document will serve as your facility’s formal commitment to the PART collaborative. As you know, PART aims to promote best practices in care transitions, to facilitate discussions among providers, to track statewide progress, and to act as a resource to your hospital as you engage in care transitions quality improvement.

To facilitate your work, the Partnership for Health is offering the tools and resources of the BOOST online community and data tracking portal. This service would normally cost each individual hospital thousands of dollars, but as part of the collaborative you will have free access. Your team will also have access to the Care Transitions Improvement Advisor, Laura Cole RN, MSN and BOOST mentor Neal Axon, MD, MSCR. We are excited to assist your team in developing a care transitions action plan and to provide individualized coaching along the way. In order for your facility to track your progress and have access to benchmarking data, it is extremely important that your team enters process measure data each month. We will work with the South Carolina Office of Research and Statistics (ORS) to provide you with hospital specific outcomes data on a quarterly basis. The BOOST portal also gives your team the flexibility to enter other types of data of interest to you in order to meet the needs of your specific program.

As you will note, there are 2 separate DUAs. The first is for the quality improvement program, and in this area PART has multiple partners. We have worked very hard to reduce redundancies in data collection and reporting. For those hospitals participating in the South Carolina Affinity group through Premier, care transitions record data you enter on the BOOST portal will be transferred automatically to the Premier website. This will make your data entry easier for the READ1 measure. For those hospitals participating with CCME care transitions efforts, we will also share relevant data with CCME for their sponsored measures.

The second DUA is to extend our new knowledge regarding the prevention of avoidable readmissions through research. The PART leadership team would like to incorporate a research component into the PART collaborative, in an effort to expand and share the new knowledge that is discovered. There is a separate DUA for hospitals interested in participating in this component, allowing the research team to utilize your data for specific research projects, in a de-identified and Institutional Review Board approved manner.

If you have questions or would like to discuss the benefits and commitments of this collaborative in more detail please contact Laura Cole at 803-454-6968.

Best regards,

Thornton Kirby
President and CEO
SC Hospital Association

Jim Deyling
President
Blue Cross Blue Shield of SC

Jay Moskowitz
President and CEO
Health Sciences SC
Our Opinion

Aviation Authority needs a champion

When board Chairman Chip Limehouse suggested the executive director of the Charleston County Aviation Authority needed oversight, he might have been right. But other than vague comments about Executive Director Sue Stevens' previous travel expenses, Limehouse, who is also a state representative, offered no specifics at the agency’s Sept. 4 meeting.

That day, the board voted to have Stevens answer directly to Limehouse. Nearly two weeks later, the board unanimously rescinded that decision.

The 13 days between votes afforded a glimpse into what appears to be a dysfunctional agency that relies on a strong staff to keep the airport running and underscores a lack of board-level leadership.

Another board member, state Sen. Chip Campsen, recently questioned the constitutionality of having lawmakers serve on the board. He also refused to actively participate in the business of the board and appointed a proxy to make decisions.

These are two lawmakers who could provide leadership and guidance instead of abdication and micromanagement. The people of Charleston County and South Carolina and the businesses impacted by the Aviation Authority require better.

Campsen didn’t ask for the job. He became a board member by state law when he became vice chairman of the Charleston County Legislative Delegation, which occurred when Lt. Gov. Glenn McConnell was appointed state attorney general of the state of South Carolina.

He gets to sit in on meetings but, once lawmakers ask for the public’s trust, they can’t pick and choose how and when they will serve.

The latest eruption where Charleston Mayor Joe Riley repeatedly challenged Limehouse and the board to follow the letter and intent of the state’s open meetings law revealed a governing body that has clearly lost its focus.

The Charleston County Aviation Authority needs a champion with conviction.

If Campsen thinks the governing legislation is unconstitutional, then he has an obligation to work with the delegation to fix it instead of just shout- ing from a distance by proxy. If Limehouse thinks the executive director needs more oversight then he should say why and give Stevens a chance to respond instead of suggesting there’s some wrongdoing without providing any evidence.

Solving the pressing problem of avoidable hospital readmissions

By Jim DeLing and Rick Foster

There is a comprehensive effort under way in South Carolina to reduce avoidable hospital readmissions. This effort will not only foster quality improvement in patient care but also save millions of dollars.

Why should actions taken in the health care community matter to the business community? Aside from the instability that some point to, we and those close to us will be patients needing the highest quality care. There is an equally pragmatic reason: medical expense is the biggest driver of rising health care costs.

Access to transforming technologies and drugs coupled with expertise of professionals providing 24-hour care comes with a price. Unnecessary rising health care expense imposes a financial burden that affects business owners and employees alike. It impedes our ability to compete at all levels in the marketplace.

How to mitigate the rising trend of health care costs is one of the most pressing questions facing business owners today — but before one can find solutions, one must identify specific problems.

National statistics tell a concerning story. Hospitalizations account for almost one-third of the $2.5 trillion spent annually on health care in the United States. While most of these stays are appropriate and necessary, nearly one in five patients discharged from hospitals is readmitted within 30 days. South Carolina’s statistics mirror those of other states. This is a national trend.

According to the Medicare Payment Advisory Commission, up to 76% of these re-hospitalizations within the Medicare population could be avoided — potentially saving more than $20 billion in the nation’s health care system.

Now, there is an added sense of urgency in addressing the issue of readmissions. In 2013, new federal regulations reduce Medicare reimbursement to hospitals that do not cut preventable readmissions by 3% and other health care-acquired conditions by 40%. Under these guidelines — without improvement — South Carolina hospitals are at risk to lose nearly $5.7 million in annual funding. We cannot allow that to happen.

To tackle this problem, the South Carolina Partnership for Health, a collaboration of the leadership of the South Carolina Hospital Association, BlueCross BlueShield of South Carolina and Health Sciences South Carolina, together with The Carolina Center for Medical Excellence, will launch its inaugural campaign, Preventing Avoidable Readmissions Together (P-A-R-T).

This collaboration has put a stake in the ground with an ambitious goal: Hitting South Carolina’s lead in the nation in readmission rate improvement by 2015.

We will do that for each individual patient by sharing data and outcome measures that are adjusted to take into account the severity of illness. We will also improve the communication and transitions involved in treating patients with complex conditions. From primary care physicians to specialists and from hospitals to other care facilities.

Our first step toward success is raised awareness of the problem. The statewide campaign begins in earnest on Sept. 20, with a symposium that being promoted to hospitals and community providers as an informational and action network.

Public messaging is not far behind. There is a key role for patients and their families in achieving this kind of improvement, sometimes requiring changes in behavior. Effective communication is vital.

Again, this focus is on avoidable readmissions. Certainly there are some patients who are too sick or frail to participate in their care. However, other patients need to understand how to manage their conditions. Caregivers must identify any barriers that may prevent patients from effectively following doctors’ orders so that if needed, early intervention can stave off more serious complications later.

In achieving our goal, we anticipate not only avoiding the $20 billion dollars penalty from Medicare; we also anticipate statewide cost savings of $400 million.

Nevertheless, achieving even this significant cost savings alone does not qualify as success. The mission of the South Carolina Partnership for Health is to enhance the state’s competitiveness by improving the health of its citizens.

Within that construct, two other fundamental elements must be taken into account — enhanced patient experience and improved quality outcomes. When combined with cost savings, they add up to achieving the Triple Aim, a relatively new term in health care circles that represents the ideal. More and more, Triple Aim is the benchmark for success in medicine.

It is reason to be optimistic, that we can achieve the Triple Aim. At no other time in health care has there been such willingness to collaborate and share best practices, in all the name of achieving common goals of performance improvement.

So we return to the question. Why should actions taken in the health care community matter to the business community? You now know the answer.

Jim DeLing is president of private business at BlueCross BlueShield of South Carolina. Rick Foster, M.D., is senior vice president for quality and patient safety at South Carolina Hospital Association.
PART Discharge Summary Format

1. Preliminary Information (Spell All Names)
   a. Patient Spelling, Med Rec #
   b. Dates of Admission/Discharge
   c. Attending Physician, Service
   d. Person Dictating
   e. Referring/Primary Care Provider (include contact information)
   f. Discharge Diagnoses (primary and secondary)
2. Admission Information

a. Chief Complaint on Admission

b. Hx Present Illness (Brief, including presenting symptoms and admitting impressions/diagnoses)

c. Pertinent Past Med. Hx, Past Surgical Hx, Social Hx, Family Hx

d. Allergies/Reactions

e. Admission Physical Exam (Pertinent findings only)

f. Diagnostic Tests (Pertinent test results only; recite key findings rather than entire reports)

g. Procedures (List major/invasive procedures)

h. Consultations (List services, key findings)

The PART Initiative is jointly sponsored by the South Carolina Partnership for Health and the North and South Carolina Quality Improvement Organization, The Carolinas Center for Medical Excellence
The PART Team

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Neal Axon, MD
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  Judy Baskins
Maggie Bobo
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Ashley Kay Childers, PhD, CPHQ
Laura Cole, RN, MSN
Michael Craig, MD
  Stephen Creech
Tom Diller, MD
Cheryl Dye, PhD
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Rick Foster, MD
Greg Gattman
Reg Gilbreath, MD
  Sherri Hayes
Bill Hester, MD
Coy Irvin, MD
Mary Margaret Jackson
  Darcy Kalles
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Kathy Landis
Mary Hellen Leezan
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Peggy McKinney
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Tanishah Nellom
  Greg Nobles
Jim Raymond, MD
Chris Rees
Karen Reeves
Angie Roberson
Renee Romberger
Theresa Seaberg
Windsor Sherrill, PhD
Conrad Shuler, MD
Frank Smeeks, MD
Sandra Thompson
Mike Tillirson, MD
Melanie Tolle
Ron Vigus
March 20, 2013

Dear Hospital Partner,

We thank you for your interest in the Preventing Avoidable Readmissions Together (PART) Collaborative, the first focused health care initiative under a new collaborative partnership called the South Carolina Partnership for Health (SC PfH). We are excited to offer this collaborative to improve patient care throughout South Carolina and without your participation, this would not be possible.

It has come to our attention that several hospitals have voiced concern regarding signing the data use agreement (DUA) prior to knowing the intentions of SC PfH. In particular, will the individual partners utilize the data outside the constraints of the DUA for the benefit of the individual partners? The SC PfH partners include BlueCross and BlueShield of South Carolina, Health Science South Carolina, and the South Carolina Hospital Association. We want to emphasize that in addition to the language in the DUA that prohibits such conduct, this letter is to ensure and confirm that the individual entities will only use the data to improve quality of transitional care within the context of SC PfH. The data cannot be shared outside of the South Carolina Partnership for Health structure for individual partner use.

We appreciate your consideration to join the PART Collaborative to improve the transition of care for all patients in South Carolina and look forward to working with you.

Respectfully Yours,

Jim Deyling, Chairman
Partnership for Health Chairman
DATA USE AGREEMENT
For Research within the PART Collaborative

1. This Data Use Agreement (DUA) is between The South Carolina Partnership for Health (SCPfH) which includes Health Science of South Carolina, Blue Cross and Blue Shield of South Carolina and South Carolina Hospital Association), South Carolina Hospital Association (SCHA), and __________________ (hospital). This DUA grants the SC PfH research committee permission and access to the de-identified outcomes data for data analysis and publication related to the Preventing Avoidable Readmissions Together (PART) Collaborative [Health Insurance Portability and Accountability Act (HIPPA) compliant]. Hospital participation in this research component is voluntary.

2. Data Collection and Use: The Hospital authorizes SCHA to obtain and provide de-identified aggregate hospital readmissions and outcome data to support research within the PART Collaborative. SCHA staff will utilize the ORS data repository for selected data elements. The aggregate de-identified readmission and outcome data will be shared with SC PfH and utilized for evaluation and implementation of potential research projects.

3. Conditions of Data Use:
   a. There will be no additional use or further disclosure of the Limited Data Set or any information contained therein other than as permitted by this Agreement or required by applicable law.
   b. There will be appropriate safeguards in place to prevent additional use or disclosure of the Limited Data Set or any information contained therein other than as provided for by this Agreement.
   c. Representatives of SCHA or SC PfH will immediately report to member hospitals any use or disclosure of the Limited Data Set or any part of it not provided for by this agreement of which user or any authorized party becomes aware.
   d. To ensure that any agents, including subcontractors, to whom user or an authorized party provides the Limited Data Set or any part of it agree to the same restrictions and conditions that apply to the User and Authorized Parties under this Agreement.
   e. Information contained in the Limited Data Set will not be used to identify individuals whose information is contained in the Limited Data Set, nor to contact them under any circumstances.

4. Hospital data will be utilized for research pertaining to care transition, readmission reduction and outcome activities. These activities will have Institutional Review Board approval and be compliant with all stated research regulations.

Remainder of page 1 left blank intentionally.
DATA USE AGREEMENT
For Research within the PART Collaborative

AGREED AND ACCEPTED BY:

Member: Printed Name_______________________________________
Signature_____________________________________________________ 
Title__________________________________________________________
Date___________________________ _______________________________

South Carolina Hospital
Association: Printed Name_ Thornton Kirby
Signature_____________________________________________________ 
Title_ President and CEO, South Carolina Hospital Association
Date__ 01/08/2013

Partnership for
Health: Printed Name_ Jim Deyling
Signature_____________________________________________________ 
Title_ President, BlueCross BlueShield of South Carolina
Date___ 01/08/2013
PART:
Preventing Avoidable Readmissions Together

Data Use Agreement

Thank you for agreeing to participate in “PART: Preventing Avoidable Readmissions Together.” South Carolina Partnership for Health (SC PH), South Carolina Hospital Association, and Health Sciences of South Carolina, Society of Hospital Medicine, The Carolinas Center for Medical Excellence (CCME) have partnered with the Society of Hospital Medicine (SHM), Project BOOST to develop and offer a statewide Care Transitions Collaborative to South Carolina hospitals. The goal is to reduce statewide avoidable readmissions by 20%. SC PH, SHM and CCME are equally committed to supporting this goal and helping your organization reduce preventable readmissions, improve outcomes and safely reducing costs.

This document, Data Use Agreement (DUA), outlines the commitments that will be required to share data with each partner of the PART collaborative - SC Partnership for Health (Blue Cross/Blue Shield of SC, South Carolina Hospital Association and Health Sciences of South Carolina), Society of Hospital Medicine, The Carolinas Center for Medical Excellence and Premier. PART Leadership will utilize the Society of Hospital Medicine’s database to share information regarding progress, and we will coordinate data collection, best practices and improvement strategies. Please review the DUA terms outlined below and return a signed copy of this letter agreement (“Agreement”) to Laura Cole (contact information on page 4) to formalize your commitment to participate in the PART collaborative.

1. This data use agreement is made by and between, SC Partnership for Health (Blue Cross/Blue Shield of SC, South Carolina Hospital Association and Health Sciences of South Carolina), Society of Hospital Medicine, The Carolinas Center for Medical Excellence, Premier and the organization named below hereinafter referred to as “member”:

   ____________________________________________________________________________

   Name of Participating Organization
   (If more than one hospital is represented, please list the name of the entire health system above. Under item 6 of the DUA, list the name of each individual hospital, for which data will be submitted.)

2. This DUA specifies the terms and conditions of member’s data submission in PART hereinafter referred as the “database.”

3. The purpose of the database is to provide facility specific and statewide analysis of hospital performance in avoiding readmissions. This database will also provide a validated process to evaluate specific components of the PART program as well as provide both process and outcome data in a standardized format.

4. Data collection:

   a. Member agrees to provide specified monthly data elements into the database for analysis and reporting. By agreeing to participate in the database, member agrees to make a good faith effort to provide data for analysis and evaluation.
   b. Member authorizes SCHA to obtain i) de-identified, aggregate Member readmission information to support the creation of the outcome measures for the Boost portal by utilizing The South Carolina Office of Research and Statistics (ORS) and ii) The de-identified, aggregate Member readmission information shall be shared with the SC.

Version: 11/27/12
PART:

Preventing Avoidable Readmissions Together

Partnership for Health (Blue cross/Blue Shield, South Carolina Hospital Association and Health Sciences of South Carolina), Society of Hospital Medicine, CCME and *Premier Hospital Engagement Network/SC Affinity Group.

c. *For those hospitals that are involved in the SC Affinity Group, Member authorizes that the numerator/denominator data for the care transition measures will be transferred from the BOOST portal to the Premier data site by data upload through SCHA. Information on the specific measure is outlined in the Premier Guidelines as required by the Partnership for Patients initiative (“PFP data”).

5. **Conditions of Use.** User and each Authorized Party agree as follows:

   a. Not to use or further disclose the Limited Data Set or any information contained therein other than as permitted by this Agreement or required by applicable law.
   
   b. To use appropriate safeguards to prevent use or disclosure of the Limited Data Set or any information contained therein other than as provided for by this Agreement.
   
   c. To report to SHM, through the SHM BOOST Project Director or representative, any use or disclosure of the Limited Data Set or any part of it not provided for by this Agreement of which User or any Authorized Party becomes aware.
   
   d. To ensure that any agents, including subcontractors, to whom User or an Authorized Party provides the Limited Data Set or any part of it agree to the same restrictions and conditions that apply to the User and Authorized Parties under this Agreement.
   
   e. Not to use the information contained in the Limited Data Set to identify the individuals whose information is contained in the Limited Data Set, nor to contact them under any circumstances.
   
   f. The protections of this agreement will be extended to the data set until the data is destroyed, returned to SHM or for a 5 year period upon written request by SHM

6. **Member Data will be used for the following purposes:**

   a. Hospital specific data will be shared between Partnership for Health (Blue Cross/Blue Shield SC, South Carolina Hospital Association and Health Sciences of South Carolina) and CCME for the purpose of assessing progress, guiding and strengthening improvement efforts and evaluating the facility specific and statewide impact of the initiative. SC PIH will be responsible to create and distribute hospital specific progress reports to be used as a benchmark resource for each hospital.

7. **Please specify each facility in your system to be included under this Data Use Agreement**

   Hospital Name _________________________________________________
   
   Address ___________________________________________________________
   
   Project Team Lead _______________________________________________
   
   Project Team Lead Title ___________________________________________
   
   Email _____________________________________________________________
   
   Phone Number ____________________________________________________

Version: 11/27/12
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AGREED AND ACCEPTED BY:

**Member:**
Printed Name ____________________________________________
Signature ____________________________________________
Title ____________________________________________
Date ____________________________________________

**Society of Hospital Medicine:**
Printed Name ____________________________________________
Signature ____________________________________________
Title ____________________________________________
Date ____________________________________________

**Partnership for Health:**
Printed Name ____________________________________________
Signature ____________________________________________
Title ____________________________________________
Date ____________________________________________

**South Carolina Hospital Association:**
Printed Name ____________________________________________
Signature ____________________________________________
Title ____________________________________________
Date ____________________________________________

**Carolinas Center for Medical Excellence:**
Printed Name ____________________________________________
Signature ____________________________________________
Title ____________________________________________
Date ____________________________________________

ACKNOWLEDGED BY:

**Premier:**
Printed Name ____________________________________________
Signature ____________________________________________
Title ____________________________________________
Date ____________________________________________

Return your completed DUA to:
Laura Cole, RN
Partnership for Health, Care Transitions Lead
Email: lcole@scha.org
Fax: (803) 796-2938, Phone: (803) 454-3568

Version: 11/27/12