Cyberseminar Transcript

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Session: The ED-PACT Tool: Communicating Veterans’ Care Needs After ED Visits

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Moderator: We are at the top of the hour now so I would like to introduce our speaker. We are very grateful to have Dr. Kristina Cordasco joining us today. She is core investigator of the Center for the Study of Healthcare Innovation, Implementation & Policy and internal medicine physician at VA Greater Los Angeles Health Care System. She’s also an associate clinical professor of medicine at the University of California in Los Angeles. At this time, Dr. Cordasco, I’d like to turn it over to you.

Dr. Kristina Cordasco: Thank you so much, Molly, and thank you for the opportunity to present today. Are you able to see my screen?

Molly: Looks great. Thank you.

Dr. Kristina Cordasco: Great. I have no conflicts of interest to declare. So I would like to start off by getting to know you all a little bit. So I would like to ask for us to do a poll. The poll question is which of the below roles best describe you? Now I know a lot of us have multiple roles so go ahead and choose all that apply. Are you a PACT team member? Are you an ED provider or staff member? Are you a quality improvement or implementation leader? Are you administrative leader and/or a researcher? Go ahead and select all that apply.

Molly: Thank you. We do have the answers streaming in, a nice responsive audience. If you’re not seeing your exact role here, please note that at the end of the session I will put up a feedback survey with a more extensive list of roles so you might be able to find yours in there to select. Okay, it looks like we’ve had over 85% response rate. That’s great. So I’m going to close this out and share those results. Looks like 42% of our respondents selected PACT team member, 3% ED provider or staff, 42% quality improvement or implementation leader, 16% administrative lead, and 32% researchers. Thank you to those respondents, and I will turn it back over to you now.

Dr. Kristina Cordasco: Fabulous. So quite a mix of participants today. I’m very excited about that. So I would like to turn to telling you about my objectives for this presentation. I will first provide a broad overview of the current literature on emergency department follow-up care, and then I will turn to describing the ED-PACT Tool. I will describe its development process, the tool’s key features as well as our informative evaluation results. And then we’ll open it up for questions and answers. And I would specifically love to also hear from you in the comment period what are the features of the tool that you think may or may not be applicable to the sites where you are or how it might be able to be changed in order to make it more applicable? So please keep that in mind as I’m presenting today.

So the presentation today focuses on emergency department treat-and-release visits, and those are emergency department visits resulting in discharge home or to a non-hospitalized setting such as a skilled nursing facility. And nationally, both within VA and outside of VA, most emergency department visits are treat-and-release visits. And we know that patients with emergency department treat-and-release visits are vulnerable for experiencing adverse outcomes.

Across studies, 5 to 19% of patients with an emergency department treat-and-release visit have a repeat emergency department visit within 30 days. And among a cohort of seniors discharged from the emergency departments in Quebec, in 30 days following that emergency department visit, 1% had died and 5% were hospitalized. Given this, some have asserted that among elderly patients in particularly, and you may expand that to those with chronic comorbidities, a treat-and-release emergency department visit should be treated as a sentinel event.

The patients may be especially vulnerable if they have post-emergency department follow-up care needs. And this is very common. Examples of common follow-up care needs include wound care, repeat laboratory or radiology tests, blood pressure recheck, or sign or symptom reevaluation in the days to weeks following the emergency department visit. These patients not getting the care that they need in the period following the treat–and-release emergency department visits are prone to communication failures. And these are often not communicated to the follow-up care providers. And so the patient is expected to convey the message and arrange for the care, yet often patients don’t understand the care that they need. And that is why this period following the treat-and-release emergency department visits are prone to communication failures.

There have been consistent findings in studies assessing the patient understanding of emergency department discharge instructions. This is the findings in one such study. I’ve displayed here among 140 English speaking adults discharged from academic and community emergency departments. In that study, 15% of the patients or their caregivers did not understand their emergency department diagnosis or the cause for their visit; 29% did not understand the care that they had been provided within the emergency department, and this is key; 34% did not understand the post-ED care instructions. So what they needed to do following the emergency department. And 22% did not understand the instructions or the return precautions when they should come back to the emergency department.

So there are numerous explanations for these high rates of not understanding, some of which can be provider communication issues. But the ED is inherently a very chaotic environment. Patients by definition are acutely ill and some will be discharged in the middle of the night. So bottom line, relying on patients to convey the message about and how to understand how to arrange follow-up care is at best sub-optimal, yet often that is what is done. So it should not be surprising that many patients do not receive the emergency department follow-up care that they need. Among a thousand patients discharged from emergency departments to an outpatient referral network with the recommendation to have follow-up care appointments, two-thirds did not receive that follow-up care.

In another study among 250 patients discharged from an academic emergency department, and they were actually given an appointment before they left the emergency department, 41% did not receive that follow-up care. And the rate was even higher among another cohort in that same emergency department who were not given an appointment where 63% did not receive the care that was recommended.

So given the high frequency of emergency department treat-and-release visits and the vulnerability of the patients with these visits to not getting the follow-up care that they need and experiencing adverse outcomes, in this past year the National Quality Forum convened a stakeholder panel to examine this issue. And the recommendations from that panel were that the emergency departments and healthcare systems should expand their infrastructure and enhance health information technology supporting this care transition from emergency department to the follow-up ambulatory care. Develop new payment models and levers to facilitate quality improvement in this area. And then third, establish a research agenda in support of these transitions.

So that is the general literature in a survey of what is known about non-VA settings, but what about within VA? Maybe we’re different since we’re an integrated healthcare system and things like the payment models are not as applicable to us, and we have an integrated medical record system. Well, in fact, the situation is mirrored in VA. There’s actually a paucity of data, however, but the paucity of data shows that between fiscal years 2010 and 2014, 38% of VA users had one or more VA ED visits, and 80% of VA ED visits were treat-and-release. So this is a topic that is highly relevant to VA and perhaps even more so because Veterans with VA ED visits are more likely to be older. They have complex medical histories compared to community ED patients. So again, highly relevant to VA, but what do we know about how well VA does at getting Veterans the care they need following VA ED visits?

So unfortunately we don’t know as much about this as perhaps we should. Dr. Nicki Hastings in Durham has really done the entirety of the work in this area. She and her team showed that among 942 older Veterans discharged home from the Durham VA Emergency Department in 2003, 34% had a return emergency department visit, were hospitalized, and/or died within 90 days, so high rates of adverse outcomes. And in a national assessment, national across VA of emergency department visits between 2007 and 2008, 53% of Veterans did not have an outpatient provider follow-up within 30 days, and 72% of those with repeat emergency department visits had no intervening follow-up between the time of their first and repeat emergency department visit.

In a smaller study she did among 24 Veterans in the 2003 Durham Emergency Department cohort who had received a diuretic, newly prescribed at emergency department discharge, and therefore needing a follow-up laboratory, only 50% received the care that they need. A very small study, but given that this is a patient safety issue, perhaps very concerning and an indicator of other types of patients who need follow-up care. But the first thing you may have noticed about all of this work is that it pre-dates PACT implementation and therefore really shows that follow-up assessments and more detailed assessments are needed within VA.

So to summarize the literature to date, patients are at high risk in general for having adverse outcomes following treat-and-release emergency department visits. And for patients who are older or have multiple chronic conditions, this could be considered a sentinel event, having a treat-and-release ED visit. Communication errors may result in these vulnerable patients not getting the follow-up care that they need, and Veterans with VA ED visits are potentially at risk for this as well. And more research and attention to this topic is needed. And assessment of VA’s current state post-PACT implementation is needed.

So with that, let’s engage in a mini, very informal, and most definitely a convenience sample assessment among those of us participating in this Cyberseminar by responding to this poll question. How would you write the communication and coordination of care between the emergency department and follow-up care providers in your VA facility?

Molly: Thank you. So for our attendees, as you can see on your screen, the answer options are completely sufficient, moderately sufficient, minimally sufficient, not at all sufficient, or no opinion/not applicable. And it looks like we have about three-quarters of our audience respond. I’ll give people a few more seconds to get their opinion in. Okay, I’m going to go ahead and close this out and share those results. Seventeen percent replied moderately sufficient, 44% minimally sufficient, 9% not at all sufficient, and 30% no opinion or not applicable. Thank you to those respondents, and I’ll turn it over to you for the last time, Kristina.

Dr. Kristina Cordasco: Great. So if you had asked that question to providers and staff at the Greater Los Angeles VA a few years ago, most would have said that communication mechanisms were minimally or not at all sufficient, which is what prompted the development and implementation of the ED-PACT Tool which I’m going to tell you about next.

So to tell you more about the problem that we had at Greater Los Angeles, a few years ago, we had no systematic or reliable method for communicating and arranging for post-emergency department follow-up care needs. Patients with follow-up care needs were often being told by our ED clinicians to walk in and see their PACT providers in order to get the care they needed, which created a lot of disruption within the PACT teams. When there was any uncertainty about whether the patient could walk in, so if the patient replied to the emergency department provider, oh, I can’t do that, that they won’t let me because they don’t really, weren't that familiar with the PACT teams, they were being told by the ED clinicians, well, then return to the emergency department in order to get your follow-up care, which was resulting in many repeat emergency department visits for follow-up care when it was not urgent and not needed to be seen in the emergency department.

Patients were being told to follow up with PACT teams for an appointment in two days. Routinely, all patients were being told this by many providers as a safety mechanism in case their symptoms got worse. They wanted somebody to check in with the patient just make sure they are doing fine, responding to treatment and not getting worse. And so they would just tell them follow up with your primary care team within two days, which was creating many unnecessary visits and therefore not allowing those visits to be used for other patients who may really need them.

It also, our system relied on, or lack of system relied on the primary care providers assessing or acting on all ED-related alerts immediately. So we did have a system where all emergency department visits resulted in an alert to the primary care provider that the patient was seen in the emergency department. And the primary care provider could be put on as an additional signer to the ED notes. And sometimes the primary care provider would quickly read the emergency department notes and make an assessment that this patient did have urgent or a specific care need and then direct the PACT team to reach out to that patient. However, this was inconsistent, and there was no way for the system to track whether this was happening. If a primary care provider got behind on their alerts, which of course, amongst the myriad of alerts that primary care providers are getting, this was somewhat understandable, then the patient was at risk of not getting the care that they needed. And so in all, some patients were not getting the needed care that they needed in a timely fashion, and they were returning to the emergency department with a progression of their illness from having not gotten that care.

So this problem was encapsulated by a patient that I cared for in our emergency department. This was an 85-year-old male Veteran seen at the West Los Angeles Emergency Department by a different provider previous to me meeting him. And he was diagnosed with pneumonia and a mild congestive heart failure exacerbation. He was started on an antibiotic and his diuretic was increased. The ED doctor thought he needed close follow-up but unsure whether this patient could get his follow-up in primary care, told the patient to return to the emergency department two to three days later for reassessment. So three days later his 80-year-old wife drives him two hours to return to the emergency department and see me, and then they wait two hours to see me. It was a very busy day. I walk in the room and ask how he is doing, and the wife says he is much better. His energy and breathing are both better and the swelling in his legs are completely gone.

Now I understand why the first emergency department doctor asked him to come back. He was elderly, and he was a little worried about him, needed somebody to check in and make sure that this patient was doing okay. However, the local PACT team could, of course, done this if there had been a reliable way of communicating this need to the primary care team. And it was this patient that started the talking and discussions about the ED-PACT Tool at Greater Los Angeles.

So the objectives of the ED-PACT Tool are to improve communication between the VA Greater Los Angeles Emergency Department and our PACT clinics. And the project developed, piloted, and formally evaluated an electronic medical record-based tool to support communication of care for needs of patients discharged from VA EDs.

So the first step in its development was to assess the literature. We assessed various topics within the literature. ED follow-up care and other care transitions. For example, the hospital to home transition is very analogous to the ED to home transition, and therefore, we drew on that literature. We drew on the literature of best practices in communication across hand-off, and we found that best practices includes having standardized processes and forms and leveraging existing health information technology and creating closed-loop communication systems. And we looked to the health IT literature on usability heuristics. So what are the features of health IT system that make them maximally usable by their users?

And we formed a multidisciplinary stakeholder workgroup, and this was truly a key step is getting a workgroup together that encapsulated, of course, included not only myself but the stakeholders from both the emergency departments, so two emergency department clinicians, so the providers who were sending these patients to primary care. But also the PACT team members and representatives from both primary care providers, the RN care managers, and the clerks because the clerks were the ones receiving the phone calls and doing scheduling for post-emergency department visits. And then also because of the literature on the importance of leveraging health IT, we included a clinical applications coordinator, which locally we had a clinical application coordinator who is a pharmacist with primary care experience so understood how the primary care teams worked as well.

And this team didn’t start off going straight to the intervention but really spent quite a few meetings exploring emergency department and PACT processes. This was over three meetings, explored emergency department and PACT processes, expectations, and frustrations. So really talked through what each side was experiencing and talked through the need to incorporate communications into the emergency department workflow so that we couldn’t create a whole, completely separate process that would take effort on the emergency department side in that the discharge and the flow of patients through the emergency department is important. And also that in our emergency department we have multiple part-time providers with high turnover of those providers so that a process that needed to take a lot of training or instruction or understanding of our healthcare system would not work well within our emergency department. And then on the PACT side, there are of course limits in the PACT team time and the in-person appointment availability. And therefore, having every patient have an appointment following the emergency department visit was not an option.

So after developing our intervention that I’ll talk to you about as well, we did a gradual rollout across our healthcare systems with multiple revisions of our intervention and formed by rigorous formative evaluation. And all failures were investigated for root causes. We aggressively sought buy-in and feedback from all of our stakeholders through having PACT clinic leadership meetings and in-person nurse care manager meetings and trainings at all of our sites across the Greater Los Angeles system. And this was also a key step in order to implement this intervention at Greater Los Angeles.

So what is the ED-PACT Tool? Well, it’s essentially a message from the emergency providers to the PACT RN care managers, which alerts the PACT RN care managers regarding urgent or specific post-emergency department needs of patients. It uses an order mechanism in CPRS to the PACT RNs, and we call that a care coordination order.

So this is just a visual. The message goes from the emergency department provider to the RN care manager, and then the RN care manager works with all of the members of the PACT team as well as the PACT neighborhood in order to meet the care needs of the patient.

So in an overview of the steps, it starts with the Veteran being discharged from the emergency department and having a specific and urgent PACT follow-up care need. So this is not for every Veteran who is discharged from our emergency department, only those with specific or urgent PACT follow-up needs, and therefore it flags those with the most need for follow-up care. The ED provider is prompted in using the ED-PACT Tool. This is embedded within the process of discharging. We already had a process of the provider generating after-care instructions. And within that process, the ED provider is prompted of whether the patient has an urgent or specific follow-up care need, and if the Veteran does, the ED-PACT Tool is automatically generated, which creates a standardized communication system that new and infrequent emergency department providers can use. And I will show you that in a moment.

The PACT RN care manager then receives a CPRS notification regarding the order. It pops up in the notifications section, which I will show you. And therefore this system utilizes our existing electronic health record system, which was one of the best practices for hand-off. And the RN care manager works with the PACT team then to address the care need. And the PACT team members are therefore operating at the top of their license. You’ll remember that prior to the system the entire process had to start with the primary care provider. And now the PACT RN care manager is using his or her triage skills in order to direct the message and the care need appropriately.

And then, finally, the RN care manager changes the order to complete, which creates a closed-loop communication system in which there is a feedback to the system and to the ED providers that this message has been received and that the PACT team has taken over the task of delivering this care to the patient.

So I will quickly show you some screenshots from the tool. So the process is, again, initiated with the ED provider filling in the emergency department after-care instructions note. So within that, this is a excerpt from that note. The ED provider selects whether there is a non-urgent need and the patient should just follow up with the provider at the next routine visit or a specific urgent or follow-up care need. And if the provider selects specific or urgent follow-up care need, the screen for the orders for the ED-PACT Tool will automatically pop up.

And this is what it looks like. So here on the left, the first thing the provider does is select the primary care site the patient is at, either our West L.A. which is our medical center-based primary care site, or any of our CBOCs. We’re a pretty big system so we have several CBOCs. And they select this based on the information that is being imported from PCMM here up in this orange box. So they match it word for word, and that is an important principle from heuristics in that the information is completely contained within the order of how to get from one menu to the next and that there’s consistent language. So although we have, for example, this clinic, this is L.A. outpatient center. We call this something different most of the time within our system. However, when it’s imported from a PCMM, it uses this language, and therefore, this is what would show up.

So the idea is that even ED providers who have no idea what our healthcare system looks like, they can match up this language and select the CBOC site and then the team name, so it’s West L.A. Gold 4. They can find the Gold 4 here in order to route this message correctly to the correct PACT team member without understanding our system at all.

The ED provider fills in a templated order, very brief. Based on PACT feedback, we included information about verifying the patient’s contact information. Given that many of our patients have contact information that changes frequently, a simple checkbox about the reason for the request and then a simple text box to fill in the details.

The RN care manager receives a notification, which is an informational alert that an order has been placed for a member of, a Veteran assigned to his or her PACT team.

It shows up as a care coordination order in the order section and the RN opens the order to read the message. And here is an example within this orange box. It’s embedded within the order as a message.

So then the RN care manager works with the PACT team to address the need that is in the message and writes a focused note indicating that they have initiated the care for this Veteran, the follow-up care.

And the RN changes the status of the order to complete.

So over the last two years, we have had over 4,300 uses of the ED-PACT Tool. You can see that it was, from its inception in the beginning of fiscal year ’16, we spread this out, we rolled it out across the healthcare system. And so as it was being used and available for more and more CBOCs, we went to having between 700 and 800 uses a month. This represents about 10% of our ED patients, our ED visits. This dip here in quarter four is reflective of a dip in our ED visits rate within that quarter.

And the ED-PACT Tool is being used for a variety of reasons. The most common is symptom or sign recheck. And if you think back to the patient that I presented, it would just be how is this patient’s breathing or swelling doing, much of which can be done over the phone unless, of course, they detect a problem and the symptoms are getting worse. Coordination of care for like specialized testings that the patient needs like ambulatory cardiac monitoring, coordinating any other follow-up, echocardiogram. Then wound care/check or suture removal, medication adjustments, laboratory recheck if the patient needs a follow-up creatinine or hemoglobin, radiology follow-up or reimaging. If the patient needs a follow-up chest x-ray because there was something undefined and that read came back after the patient left the emergency department or if they have a pneumonia in an unusual place, or a blood pressure recheck.

So this is the percent of orders with no clinical action after three days. It hovers at about 10%. And one of the takeaways from this is that within our system each order with no action at three days results in a repeat notification to the PACT team prompting them to follow up on this. This helps ensure that no Veterans with specific or urgent post-ED care needs fall through the cracks and creates a system approach to coordinating this care and a system of monitoring. And this is one of the main advantages of this tool is that the messages are reliably conveyed to the PACT team. Unfortunately, at this point this follow-up is manual. We have created a local dashboard in VistA report to enable this audit and then feedback to the teams, but it does take a person manually going through the dashboard and notifying each of the PACT teams.

We use this audit and feedback in order to improve our system, and reasons for overdue orders were notifications were being sent to the wrong team. We used that information in order to serially modify our menus and make them more intuitive. The RNs click on the notifications and they disappear because they are informational alerts. We are looking for technological fixes for that. Staffing has been an issue when the nurse is on leave and they have not assigned a surrogate for their notifications or the surrogate is too busy covering for two or more teams. And we do see some spikes in the non-completion rate at three days, especially around holidays are common reasons for leave. And we work with our clinics in order to figure out backup systems and have been improving on that as well.

Some technical issues in that the RN CPRS profile is not set up to receive ED-PACT Tool orders for newly assigned RNs and floater RNs. This is one of the weaknesses in that this does require manual maintenance of all of the notifications. And then when the patients have been admitted or the hospital or is in the domiciliary, and this is on the ED side when they should not have used this tool.

We have done post-implementation qualitative assessments in order to improve our tool and know how it is working. We elicited feedback from stakeholders, PACT leaders/providers, ED providers, and Veterans through in-person meetings and group and individual feedback, ad hoc feedback as well as a discussion group with the ED providers, and then conducted nine interviews with Veterans about their overall impression in improving the ED-PACT Tool or its implementation, key players in implementation, the Veteran experience, and issues to consider for sustainability at Greater Los Angeles.

And we found that the ED-PACT Tool reduces ED providers’ uncertainty about how and if Veterans will get the needed follow-up care. And some ED providers have said that they have, when on the cusp of whether to admit a patient or not because of the availability of the ED-PACT Tool have decided not to admit the patient because they knew that the PACT team would be able to follow up with the patient. It helps the PACT clinic manage their workflow and reduce walk-ins and provide care more efficiently. And the nurse care managers who really appreciate being included in the communication loop. And Veterans are receiving the indicated care and are reporting good experiences obtaining their care.

As I’ve alluded to, we have continued to have some tool challenges. Some of those have been technical, as well as organizational and staffing and difficulties when the staff are on leave and there is no RN, and there are some nurse staffing vacancies.

And I really wish I could tell you that we’ve developed and launched this tool and now it’s ready to go into autopilot. Unfortunately, that’s not the case. Some because of the limitations in our current IT system and some because of any system level intervention; it always needs monitoring. But we continue to do this twice weekly audit and feedback for overdue orders. And we continue to do validation and updating of notifications and team names, and then some rare troubleshooting with incorrectly placed orders.

So in summary, the ED-PACT Tool is useful in facilitating communication for urgent or specific post-ED follow-up care. It addresses a key patient safety vulnerability, and sending messages from the ED to PACT via the nurse care manager is feasible and useful. And further IT development would improve the tool’s value and decrease the maintenance effort.

So next steps for our team is we are applying for funding and recruiting collaborators to support testing of spread to other VA facilities with further evaluation of implementation outcomes. We have developed an implementation workbook describing the tool and the process of implementing it. We are happy to distribute that. And I will have contact information at the end for myself and if you would like to contact me, we would be happy to send you this workbook and talk about the potential of implementing this tool or modification of it at your facility. We are continuing ongoing engagement with VA informatics community regarding opportunities for technologic development. And we are applying for funding to assess the impact on clinical and Veteran experience outcomes.

I want to end with thanking my collaborators. Something like this truly takes a very substantial team effort, and so it could not have been done without each of the people on this slide. I wish I could spend more time talking about the important roles that each of these people, both from the PACT side, the emergency department side, and the facility leaders have played.

Certainly thank you to our funders. The initial quality improvement workgroup that started this process is the VISN 22 Veterans Assessment and Improvement Laboratory, VAIL, PACT Demonstration Lab which was funded by the Office of Primary Care locally. Our Office of Primary Care gave funds to the Greater Los Angeles Demonstration Lab, and this project would not have ever been launched without that support. Tool development, spread, and evaluation has been further supported by the VA Quality Enhancement Research Initiative, QUERI, as a Care Coordination Program project.

And so I do have a few slides of references and I will go though and then I will end with any questions or comments that you have. And also feel free to contact me if you’re interested in getting a copy of the implementation workbook.

Molly: Thank you, Dr. Cordasco. You just answered the first question, how can we get a copy of the workbook?

Dr. Kristina Cordasco: So please do send me an email.

Molly: Excellent. Thank you. We do have some pending questions. I just want to let the people know that joined us after the top of the hour to submit your question and comment, just use the control panel on the right-hand side of your screen. Click the arrow next to the word questions. That will expand the dialogue box and you can then submit your question or comment there. The first one, what do you do if a patient is not assigned to a PACT team yet or listed at another facility?

Dr. Kristina Cordasco: Great question. So we locally have a consult system for those patients, and on our menu for the ED-PACT Tool we have a link for that as well. It says if the patient is unassigned locally, which would include those that are assigned outside to another healthcare system, click here. And then it takes the ED provider to that menu. We have discussed folding that process into the ED-PACT Tool as well. It is just sending the notifications to different people. Those notifications go to the clinic director of the place where the patient would like to get follow-up care, assuming that place is within Greater Los Angeles. And then the clinic director appropriately triages to try to fit that patient in to the teams, even though the patient has not been assigned to the teams. And that is how we are handling unassigned patients. That is an area that is most commonly in need, as I spoke about, that there is still some troubleshooting that needs to happen. It is not uncommon, especially for our trainees in our emergency department, to try to just send messages about these patients to the teams. And the PACT nurse manager will bounce those messages back to my team, and that creates a need for intervention. So that is not a seamless part of our tool at this point and we are working on that as a system.

Molly: Thank you. The next question: Has the team considered a template rather than a care coordination order for the PACT RN? This alert would not disappear after being viewed by the RN and when signing the alert would close the loop.

Dr. Kristina Cordasco: I think that what is being referred to is an additional signer mechanism on a note template and we did consider that. We also, yes, we considered putting that as a final part of our emergency department note. Locally our additional signers, the nurse can actually take, the additional signers can be taken back off of notes. That is one consideration. There is also, with no way to query the system to make sure that the additional signer has been performed. It also is not as obvious and intuitive to the ED provider in order to put the additional signer onto the note. So the ED provider being prompted in order to send this message is a key feature. So the idea is that the ED provider on their very first shift in our ED would be able to send this message instead of needing to look up for each team who the care manager is and then put the appropriate additional signer onto the note. So there were various reasons why we have chosen to go with this order instead of the additional signer mechanism, and mostly that it was considered to be more reliable and that we could, as a system, generate the checks in real time, be able to follow up with the PACT team and say, hey, this message has not been completed. Can you make sure to address it so that no Veterans fall through the cracks?

Molly: Thank you. We do have a comment that came in. What a great patient safety initiative. Well done.

Dr. Kristina Cordasco: Thank you.

Molly: The next question: You indicated that use of the tool reduced the number of walk-ins. Were you able to evaluate if there was also a reduction in post-discharge phone calls and appropriately scheduled appointments, etc.?

Dr. Kristina Cordasco: No, we did not assess for that. And I do have to qualify that it reduced walk-ins and that was a qualitative assessment from our PACT team, and so we did not have the quantitative numbers in order to demonstrate that. As part of our search for additional funding, we hope to be able to do that. And it is such a great idea to also look for impact on phone calls. The desired or perceived impact as well of the ED-PACT Tool is that although it may not decrease the number of phone conversations, it actually may increase the number of phone conversations in that many of the care needs are being addressed entirely over the telephone, especially if it’s a sign or symptom follow-up or there is a phone call arranging that follow-up care. So if the patient needs a laboratory recheck, that message could be arranged over the telephone. And then the patient goes to the laboratory, and then there could be a follow-up phone call letting them know the results without ever having an in-person visit to the PACT team. So I do not know that would decrease the number of phone calls. However, it is designed to decrease the number of phone calls that the PACT team gets without already being aware of what the patient needs. And in fact, the PACT team may be reaching out to the patient instead of the patient needing to reach in to the PACT team and again describe what their care need was, which we know from the data where patients do not really understand what their follow-up care needs may be many of the times.

Molly: Thank you. A follow-up question came in to that. So by qualitative assessment, patients were asked their reason for the walk-in and there were fewer reports of “post-ED discharge follow-up”?

Dr. Kristina Cordasco: So by qualitative I mean from the nurses telling us how patients are getting their follow-up care. The nurses are saying that patients are less likely to walk in spontaneously and say I was in the emergency department, I need follow-up care. Rather the nurses are proactively reaching out to the patients and either taking care of the care need without the patient coming in or arranging for the time when the patient would come in, which helps them manage their workflow better. So qualitatively, I mean from the perspective of the nurses in the PACT teams.

Molly: Great. This submitter said thank you and a great presentation.

Dr. Kristina Cordasco: Thank you.

Molly: We do have another follow-up question. I believe it was to the one where patients might not be in a PACT team, yeah. So in follow-up to your answer about being listed at another facility PACT, a message will go to the PACT that is listed. Say if they are traveling to L.A. but registered at D.C. VA Medical Center, the message will go to the D.C. RN coordinator listed?

Dr. Kristina Cordasco: No, unfortunately at this point, this cannot be used across healthcare systems, VA healthcare systems. So we would not be able to send a message, for example, to the D.C. healthcare system. In that case, again, if the patient is going to be staying in L.A., there would be two choices of one, sending to a PACT team. Honestly if it’s within a few days, we will still tell that patient come back to the emergency department. So if they need a follow-up lab or wound care check and they are still going to be in Los Angeles, we will just continue to take care of that in the emergency department. If the follow-up care need is going to be after they return to their home site, we do still have to tell them to contact their PACT team at their home site and let them know to look into our system and see our emergency department note. It would be more ideal if we could work out a way to send a message across healthcare systems. If people have ideas about how that could be done, I think that would, I would love to hear that.

Molly: Thank you. People are able to write in suggestions here or contact her offline. The next question: It sounds like communication difficulties are a large factor that contributes to repeat ED visits. What other factors contribute to repeat visits that you discovered?

Dr. Kristina Cordasco: Right. The literature actually has looked at repeat ED visits more extensively than they’ve looked at communication on ED visits as well. There are both patient factors, so certainly some patients just get more ill and they need a repeat emergency department visit. And this tool interacts with that in that, of course, we want those patients to come back to our emergency department, and we want them to come back sooner rather than later. We don’t want them waiting at home. And so, again, if the RN care manager calls this patient and they’ve had a progression of their symptoms, then it may be appropriate for that RN care manager to say, you know what? You need to go back to our emergency department. And we have certainly had that happen and we consider that to be a good thing. That’s an appropriate ED revisit.

The other set of factors have to do with within emergency department care, so when there has been an error or a quality issue of the care that they received within the emergency department. And that has been the bulk of what the literature has really focused on is looking at ED revisits as an indicator for care quality and decision making within the emergency department. So if the patient was sent, if there was an error in making the decision to send the patient home or there was a missed diagnosis, obviously those go hand in hand. And that when we look at ED revisits, that has been, what has been the main focus has been errors on that side as well. And then with the other site set of literature has looked at repeat emergency department use from patient social factors, so among homeless patients. And then patient preference honestly of using after hours, and when I say preference, talking about patient convenience factors in that if they need in-person care but that needs to happen after hours that the emergency department is the place to do that. And that encapsulates most of our findings.

Molly: Thank you. When a patient goes through the ED to an observation bed on a unit, can the ED-PACT Tool still be used upon discharge?

Dr. Kristina Cordasco: No. The way we have currently configured it, the ED-PACT Tool is only for patients discharged directly from our emergency department. Some of this may be very healthcare system dependent. Our observation beds are part of our inpatient service. So our observation goes to, for example, our medicine in-patient service. And therefore, the post-hospitalization transitions and two-day PACT calls, those processes then apply for that patient. There has been discussions about whether to do the ED-PACT Tool, which would, of course, maybe not be called an ED-PACT Tool but a similar process for inpatients. I have discussed that with actually other healthcare systems, that possibility. I do think that a tool such as this could be adapted for those other transitions as well.

Molly: Thank you. We do have a comment that came in. I work at the Dallas VA. Our post-ED visits are listed in our primary care almanac, which is updated daily. PACT care managers check this ED discharge daily for follow-up. This is a great additional tool to determine the need for follow-up and decreases the number of unscheduled visits.

Dr. Kristina Cordasco: Well, thank you for that. And I am really interested in hearing how different healthcare systems are managing their post-ED communication. And I alluded to the many discussions we had prior to this tool, we definitely talked about having the PACT team or the PACT RN call all patients after the emergency department, for example. However, of course there are just so many things that our PACT RNs are doing that it really felt like that is not a viable option to add a call to all patients. And just to echo what, that comment of what this would add in healthcare systems where the PACT RNs may be calling all patients already is the ability to have a quick summary of what this patient’s care needs are, and again, the triaging of that in order to point the RN care managers’ attention and focus it on that instead of needing to read a note in its entirety and sort of figure that out. You could imagine there being, so putting in a template of a message to an RN care manager within the note as well. But this is a way of highlighting those patients, so just to echo what you said, the ED-PACT Tool could be used in conjunction with other systems as well.

Molly: Thank you. We do have enough time. Would you like to give any concluding comments or wrap up with anything?

Dr. Kristina Cordasco: No. Thank you so much for your interaction and your questions and your comments. They are very much appreciated. And again, my email [Kristina.Cordasco@va.gov](mailto:kristina.cordasco@va.gov), which is on the screen. Please continue to give your comments and your feedback. Once again, we do have an implementation workbook that has been formulated and can be distributed, and so please let me know if you’re interested in receiving a copy. I look forward to hearing from you and your continued comments. This is really something that I hope evolves further.

Molly: Great. Well, thank you so much for coming on and lending your expertise to the field, and thank you to our attendees for joining us today. I am going to close out the session momentarily. For our attendees, please stick around for just a second while the feedback survey populates on your screen. It’s just a few questions, but we look closely at your responses and it helps us to improve individual presentations as well as the program as a whole. So thank you once again to everybody for joining us. Thank you, Kristina. And we will touch base in the New Year. Happy holidays, everybody.

Dr. Kristina Cordasco: Happy holidays. Bye-bye.

[ END OF AUDIO ]