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Truman Health Services Transitions in Care Clinic Quality Improvement Initiative

Quinn Jackson

Tracy M. Carlson

Lisette Infante

Lauretta England

Alan Saint

See next page for additional authors

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Authors

Quinn Jackson, Tracy M. Carlson, Lisette Infante, Laretta England, Alan Saint, and Natalie Mariam Salas

Background

- Patients who are diagnosed with HIV but not retained in medical care have been identified as having one of the highest risks for new HIV transmissions and have higher rates of all cause mortality ^{1, 2, 3, 5}
- We identified specific subpopulations among those living with HIV who are vulnerable to being lost to follow up, namely: patients newly diagnosed with HIV and patients transitioning across the healthcare system, such as those newly discharged from inpatient facilities ⁴
- Our QI initiative reviewed the processes for ensuring these populations receive timely follow up and are rapidly prescribed anti-retroviral therapy.

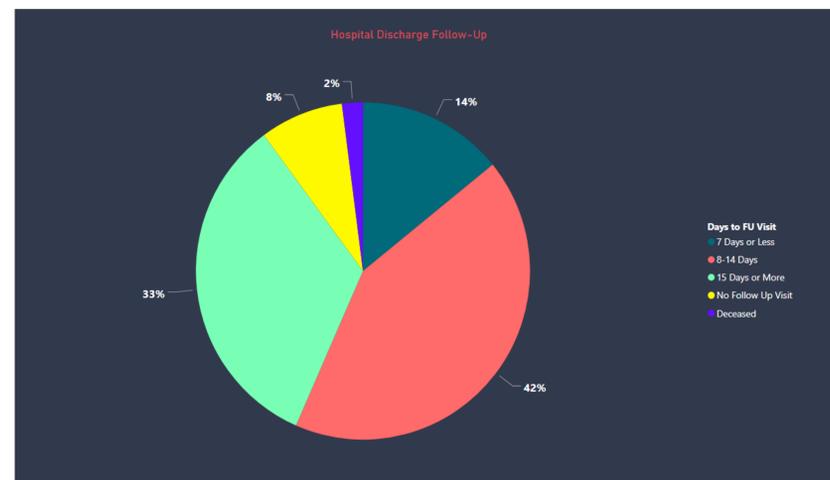
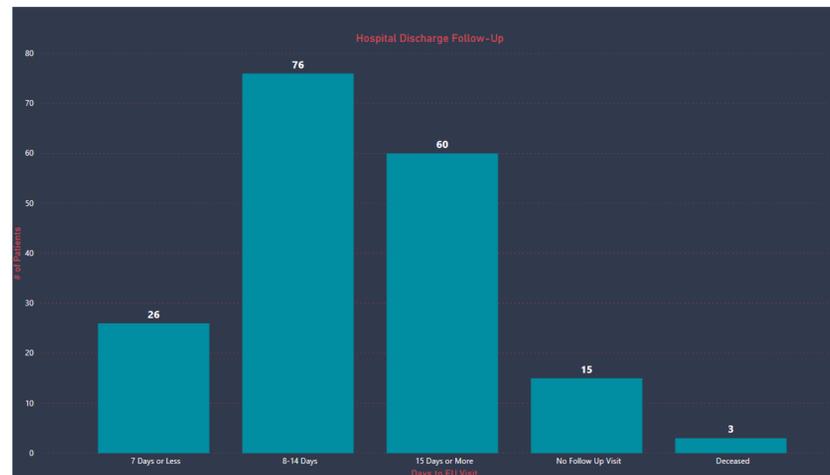
Initial Assessment

Four aims were identified:

- **Aim 1:** Ensure 100% of patients newly diagnosed with HIV are scheduled to be seen by a prescribing provider within 3 business days of being identified
- **Aim 2:** Ensure 85% of all patients living with HIV who are newly enrolled at Truman Health Services are prescribed highly active antiretroviral therapy (HAART) within 7 business days of being seen by a prescribing provider
- **Aim 3:** Ensure 85% of all patients seen in the UNMTHS TIC Clinic are prescribed HAART within 7 days of their first TIC appointment
- **Aim 4:** Ensure 100% of patients who are discharged after a UNM hospital stay are scheduled to be seen by a prescribing provider within 7 business days of being discharged
- Aims 2 and 3 were met on review of baseline data. Once we confirmed that the clinic policy stated all patients must be seen by a prescribing provider within 7 days of discharge, regardless of reason for admission, Aim 4 became the area requiring the most intervention.

Results

- **Aim 4 Analysis:** 15% of patients were scheduled for follow-up within 7 days of discharge. 48% were scheduled within 10 days of discharge. 62% were NOT seen for follow-up within 10 days. Of those: 49% were not scheduled at all, 32% were scheduled after 10 days, 9% canceled or rescheduled appointments and 8% no-showed.
- The majority of discharges not seen were simply not scheduled for a follow up with THS. Most of those were ED observation admits or surgical admits (general surgery, vascular surgery, neurosurgery, orthopedics, ENT, urology and obstetrics).



Intervention

- **Clarification of clinic policy:** We reviewed both the Care Coordination After Hospital Discharge standard operating procedure (SOP) and the Centers for Medicare and Medicaid Services (CMS) requirements. We determined our SOP requirement (7 day follow up for all patients) was more stringent than the CMS requirements while not necessarily meeting the requirements for Transitions in Care documentation.
- **Survey of nurse and provider practice:** A survey revealed a disconnect between the documented policy and the understanding/interpretation of the policy by staff. Staff perceived that 90% of patients were scheduled according to the SOP, whereas results showed only 15% were. Staff also did not recognize that the policy did not allow for triage of follow-up based on severity.
- **Revision of the clinic policy:** The clinic SOP was reviewed and modified to reflect CMS requirements and to include a decision tree for staff for appropriately scheduling patients.
- **Expansion of access to care:** We established a clinic staffed by interprofessional licensed providers (medical, behavioral health, pharmacy, nursing) with protected time to see patients post hospital discharge.
- **Evaluation:** We will reevaluate the post hospital discharge follow up practices in 1 month to evaluate for improvements.

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Disclosure: Authors of this presentation have no financial or personal relationships to disclose with commercial entities that have a direct or indirect interest in the subject matter of this presentation.