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The Alliance for Academic Internal Medicine Faculty Development Toolbox provides peer-reviewed tools to enhance faculty development and engagement.

Title: You Can Do It Too! How to Show Your Residents' Value to Your Institution Through Education in Transitions of Care

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Brief Description:

This guide is intended to assist clinician educators in creating a transition of care curriculum to teach and evaluate the following:

- Recognize and evaluate the ACGME sub-competencies of
 - Transitions of care, patient safety and quality improvement
- Resident Education and evaluation in SBP and PBLI
- Institutional Cost avoidance/ cost savings

Learning Objectives:

- 1. Recognize and evaluate the ACGME sub-competencies of
 - i. Transitions of care, patient safety and quality improvement
- 2. Identify methods and tools to institute a TOC Curriculum &Clinic
- 3. Compare and contrast best practices in TOC
- 4. Discuss barriers to implementation of a successful TOC Curriculum & Clinic

Equipment Required:

Computer with Microsoft PowerPoint, printer for handouts

Setting: Small or large group classroom setting

Total preparation time: 1-3 hours

Total time commitment for learner: 1 hour

Ideal audience size: 10-30 people

Is activity a one-time activity or a series of activities: can be both (beginner program vs advanced to improve and progress)

Intended Faculty Audience:

•	•	Community Faculty
•	•	University Faculty
•	•	New Faculty
•	•	Outpatient Faculty
•		Experienced Faculty



Comments: Faculty engaged in training and supervising residents in Transitions of Care

Delivery Type

- Didactic training
- Self-directed learning
- One-on-one coaching
- Other (please describe):mixture of didactics and one on one coaching

PREPARATION

Desired Background/Qualifications for Instructor or Facilitator: Facilitator should have at least one year of experience as clinical faculty who supervises residents in a general internal medicine clinic. Prior experience with transitions of care is optimal but not required

Preparatory Steps

Preparations and Considerations	Description
1.	4-6 weeks prior to the session, request a report of transition of care patients referred to the clinic in the previous six months.
2.	Ask the hospital quality department to compile a report of patient referred to the clinic for transition of care visits or if no Clinic yet , re-admissions data
3.	Identify stake holders and create a transition of care committee including(a champion faculty, a champion resident, social worker, pharmacist, medical assistant, clinic administrator)
4.	One week prior to the conference, the facilitator should review the presentation and the tool kit resources.

ACTIVITY

Based on the delivery mode(s) selected above, complete the following table(s) below

Didactic Training

Steps	Description	Estimated TIme	Slide Number
1	Welcome participants and introductions	1 minute	1
2	Review the learning objectives	1 minute	3



3	Brief introduction into the importance of transitions of care	2 minutes	4
4	ACGME Milestones for TOC	1 minute	5
5	Discuss Why the need for TOC and readmission rates	3 minutes	7-8
6	Discuss the institute's values that allign with the transition of care project	1 minute	9
7	SWOT analysis and discussion	10 minutes	10-14
8	Explore different methods to reduce readmission and improve TOC clinic show rate	10 minutes	15-20
9	Assign team members and define roles	5 minutes	17
10	Identifying the desired roadmap to implement transition of care	8 minutes	13
11	Review elements of TOC call, visit template, evaluation tool, billing and coding	10 minutes	28-41
12	Debrief the plan collectively and decide on follow up goals	5 minutes	54
13	Wrap up	1 minute	

Total 58-70 minutes 21 slides

FOLLOW UP

Didactic Training

Steps	Description	Estimated TIme
Evaluation	-Compile a report of patients referred to TOC for	30 mins
and	after the intervention	
Assessment	Evaluate progress on project	
	-Measure template use compliance	
Dissemination	To team members and stake holders quarterly	30 mins
of Results		

EVALUATION AND OUTCOMES

Source	Description
Piedmont Athens Regional Medical Center-Internal Meidicne residency program	Sustained transition of care project with multidisplinary team with the following results -A significant decrease of hospitalizations per patient per year with a mean difference of 1.54 (0.70-2.38) (p<0.001). the number of ED visits per patient per year decreased with a mean difference of 1.76 (0.35-3.88) (p<0.001).



-Total estimated savings= \$780 ,000 for the first three months of the project, estimated by an independent company.
-The clinic TOC show rate improved from 30% to 60% in about 1 year
- Established TOC curriculum, evaluation tools and designated team.

FURTHER STUDY/REFERENCES

- 1. Chugh A, Williams MV, Grigsby J, Coleman, EA. Better transitions: improving comprehension of discharge instructions. Frontiers of Health Services Management, 2009 Spring;25(3):11-32 2.
- 2.The Care Transitions Program, http://www.caretransitions.org/definitions.asp (accessed April 11, 2012) 3. Forster AJ, et al: Adverse drug events occurring following hospital discharge.
- 3.Journal of General Internal Medicine, April 2005;20(4):317-23 4. Medicare Payment Advisory Commission, Report to the Congress: Reforming the Delivery System, Washington, D.C.: MedPAC, June 2008
- 4. Piedmont Athens tool kit