MI-CCSI
Partnering to Better Care

SOUTHLAKE CARE TRANSITIONS, EVALUATION, AND MEASUREMENT SESSION 4 WORKBOOK

CARE TRANSITIONS, EVALUATION, AND MEASUREMENT

MI-CCSI
Center for Clinical Systems Improvement

Revision Date: 10.30.25

CONTENTS

AGENDA

Presenter	Topic	Time
Canada	Status update/activities from group	10 minutes
Team	Case Study Application	20 minutes
Sue	Transitions of Care	15 minutes
Lynn	Evaluation	15 minutes
Sue and Lynn	Measurement • Condition Considerations	15 minutes
Sue	Next Steps	15 minutes

Review the assessment tools available in the medical record today.

- Where are there opportunities for improvement or development of new assessments?
- Identify the team member who will lead this initiative.

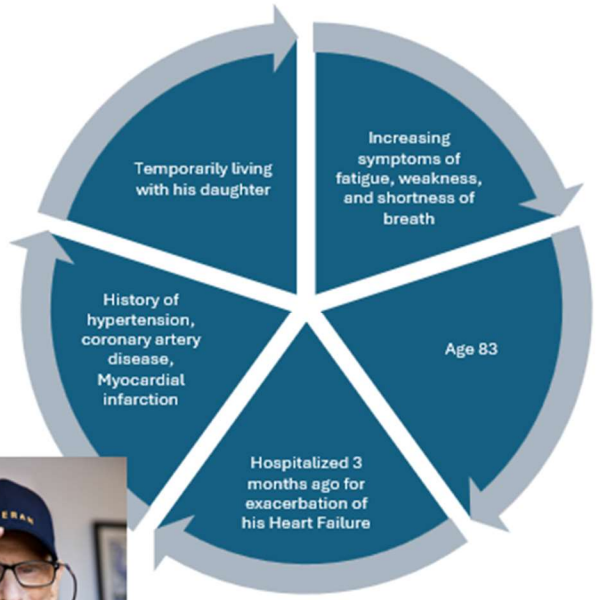
As a team:

- Determine what conditions you will start the initial focus on. For each condition, determine if there are treat-to-target goals that can be regularly monitored (ie PHQ for depression – goal is remission, a score of less than 5, A1C for diabetes – goal below X, ...)
- Finalize a self-management action plan that captures the patients motivation for healthy behavioral changes.
  - Establish a plan for implementation and use of these documents.

Review the communication tools. Select 1 tool to start with.

- Create a PDSA to identify what data you will collect to determine what is working and what requires modifications.
- Create an SBAR for one of the conditions the team would like to focus on (COPD, HF, Depression, Diabetes).
  - Discuss with the provider and clinical team members the key information needed from the situation and background for the condition in order to make decisions.

MR. B
Calls the clinic



- **Unsure about his medications**
  - Specifically, in the hospital they held his hydrochlorothiazide and on discharge did not give any directions on what to do about that
- **States feeling "low"**
- **Not following the low-sodium diet – can't stand the food without seasoning**
- **Worried about his living arrangements**
  - Wants to go back home, but his daughter is concerned about that
  - He has fallen once, no injuries other than bruises on his forehead
  - He is unable to complete his own activities of daily living without some assistance
  - Tires easily and needs help dressing
  - He can do his hygiene
- **He's having trouble sleeping**
- **He completed the SDOH screening**
  - Needs assistance with transportation to medical appointments
  - Has housing needs (based on wanting to return home)

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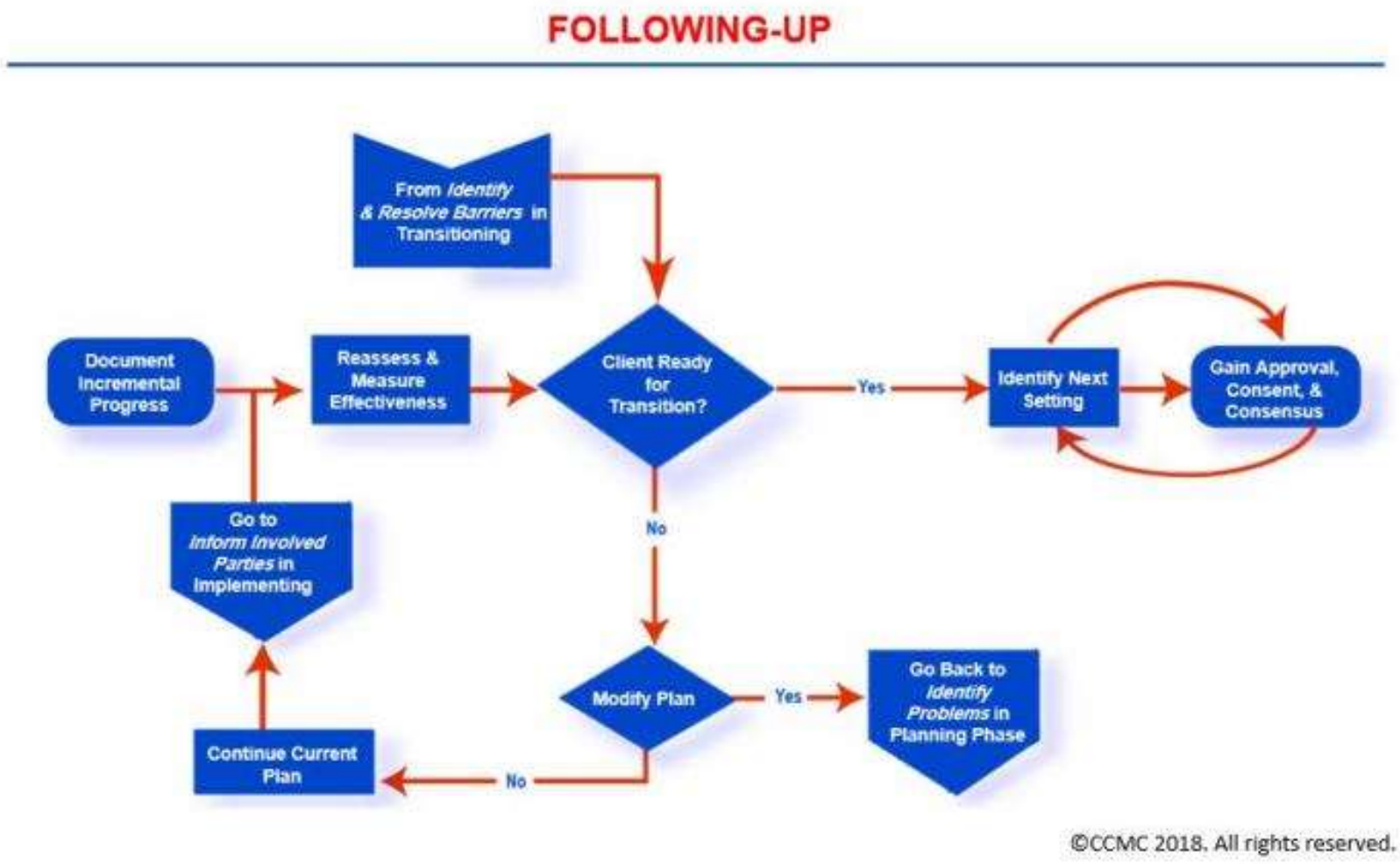
FOLLOW-UP IMPLEMENTATION



TRANSITIONS OF CARE COMPARISONS

Programs	Strategies	Description/Effectiveness
Care Transitions Intervention[40-43]	Patient engagement Individualized patient record Dedicated transition provider Facilitation of communication to outpatient providers Outreach Medication reconciliation	Focuses on 4 domains of care including self management skills Studied in several settings CCT[40,43] and RCT[41,42] Decreased 30-day readmission rates: ARR 4.9%,[40] ARR 3.6%,[41] and ARR 5.8%[43] Decreased 90-day readmission rates: ARR 5.8%[41] and ARR 21.7%[42] 30-Day ED visits: ARR 3.2% (NS)[40]
Transitional Care Model[44-47]	Patient engagement Individualized patient record Dedicated transition provider Facilitation of communication to outpatient providers Facilitated clinical follow-up Outreach	Nurse-led program studied in geriatric patients, intensive outreach with home and telephone follow-up RCT Decreased 90-day readmission rates: ARR 16.8%[44] (within 24 weeks), ARR 48.0%,[45] and ARR 13%[46] (within 6 weeks) ED visits (within 24 week): NS[44,47] Adverse events (postdischarge infection) ARR 16.7% (NS)[45]
Project RED[48]	Patient engagement Individualized patient record Dedicated transition provider Facilitation of communication to outpatient provider Multidisciplinary team Outreach Medication reconciliation (predischarge and postdischarge)	Team-based program included pharmacist outreach and medication reconciliation RCT Decreased 30-day readmission rates: ARR 5.8% (NS) Decreased 30-day ED visits: ARR 8.0%
Project BOOST[49-52]	Patient engagement Multidisciplinary team Outreach Medication reconciliation Risk assessment	Multicenter QI program with mentored implementation CCT[49] and pre–post study[51] Decreased 30-day readmission rates: ARR 2%[51] and ARR 5.9%[49]

Abbreviations: ARR, absolute risk reduction; CCT, clinical controlled trial (nonrandomized); ED, emergency department; NS, not significant; QI, quality improvement; RCT, randomized controlled trial; RED, Reengineered Discharge; BOOST, Better Outcomes for Older Adults Through Safe Transitions.

Care Transitions Models

Model	Setting	Tools/Components	Key Findings
Transitional Care Model (TCM): https://consultgeri.org/geriatric-topics/transitional-care	Hospital to home	• In-hospital evidence-based nursing care plan • Home visits þ phone follow-up with TCN • Holistic focus • Patient & caregiver education & support • Early identification & response • Patient & caregiver on team • Physicianenurse Collaboration • Open cross-communication • TCM hospital discharge screening tool for high risk older adults	• Reduced hospital readmissions • Decreased emergency room visits • Decreased healthcare costs
Care Transitions Intervention (CTI): http://www.caretransitions.org	Hospital to home	4 Pillars of CTI: • Medication • Personal health record (PHR) • Follow-up ◦ Transition Coach℠ ▪ Hospital visit ▪ Home visit ▪ 3 phone calls • Red flags	• Self-sustaining • Re-hospitalization rates @ 50% • Cost effective
Better Outcomes for Older Adults Through Safe Transitions (BOOST): http://www.hospitalmedicine.org/Web/Quality_Innovation/Implementation_Toolkits/Project_BOOST/Web/Quality___Innovation/Implementation_Toolkit/Boost/Overview.aspx http://caretransitions.org/tools-and-resources/	Hospital to home	• The target • Patient preparation to address situations (after discharge) successfully (patient PASS) • Teach-back process • Risk specific interventions • Written discharge instructions • Technical assistance	• Reduced 30-day readmission rates • Tools well-received by healthcare team and patients • Hospital and primary care provider communication and collaboration
Project Re-engineered Discharge (RED): http://www.bu.edu/fammed/projectred/	Hospital to home	• Diagnosis-related education • Post-discharge appointments, tests, etc. • Medications, diet, exercise-related education • Discharge plan reconciliation with national guidelines/clinical pathways • Emergency plan • Discharge summary transmission • Written discharge plan • Telephone call in 2e3 days	• Decreased 30-day re-hospital utilization and emergency room use • Reduced costs per subject enrolled • Increased revenue per discharge
Chronic Care Model (CCM): http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model	Clinic to home	• Community • Health care system • Self-management support • Delivery system design • Decision support • Clinical information systems • Organization assessment of chronic illness care (ACIC) • Patient assessment of care for chronic conditions (PACIC)	• Improved well-being in patients with asthma, diabetes, bipolar disorder, comorbid depression and cancer
INTERACT: http://www.maseniorcarefoundation.org/Initiatives/Care_Transitions.aspx	Nursing home to hospital	• Resource binder for champions • Case examples • Communication tools • Care path and change in condition cards • Advance care planning tools • Quality improvement	• 17% hospital admission reduction • Medicare savings • Further randomized studies to determine: avoidable hospitalizations, morbidity and cost savings

Commonalities Among Transitional Care Models

	TCM Transitional Care Model	CTI Care Transitions Intervention	BOOST Better Outcomes for Older Adults through Safe Transitions	RED Re-engineered Discharge	CCM Chronic Care Model	INTERACT Interventions to Reduce Acute Care Transfers
Hospital to home (or nursing home)	X	X	X	X		
Clinic to home					X	
Nursing home to hospital						X
High-risk patients identified	X					
Discharge planning	X	X	X	X		
Discharge instructions	X	X	X			
Medications addressed	X	X	X	X		
Early identification of potential problems	X	X		X		
Written discharge instructions	X	X	X	X		
Follow-up appointment prior to discharge				X		
Tools for health professionals	X	X	X	X	X	X
Patient & family education	X	X	X	X		
Patient-centered care	X	X	X	X	X	X
In-hospital visit	X	X		X		
Home visit(s)	X	X				
Follow-up phone calls	X	X				
Reduced hospital readmissions	X	X	X	X		X
Reduced overall healthcare costs	X	X	X	X	X	X
Improved patient outcomes	X	X	X	X	X	

From Enderlin, C.A., McLeskey, N., Rooker, J.L., Steinhauser, C, D'Avolio, D., Gusewelle, R. , & Ennen, K.A. (2013). Review of current conceptual models and frameworks to guide transitions of care in older adults. *Geriatric Nursing, 34*(1), 47-52. DOI: 10.1016/j.gerinurse.2012.08.003

Essential Elements	Description	Better Outcomes for Older Adults Through Safe Transitions (BOOST)	Care Transitions Intervention (CTI)	Transitional Care Management (TCM)
Medication Management	Ensuring the safe use of medications by patients and their families based on patients' plans of care.	Using the BOOST Assessment Tool, providers can screen patients for one of eight risk factors for readmissions, two of those being problem medications and polypharmacy (patients who are taking more than 5 medications). Risk-specific interventions are then performed using components of the BOOST Toolkit.	CTI promotes medication self-management as one of its four pillars, with the goal of ensuring that the patient is knowledgeable about medication and has a medication management system.	Medication management is a key element of TCM. Led by advanced practice nurses (APNs), medication reviews are done to identify discrepancies and inappropriate prescriptions.
Transition Planning	Creating a plan/process that facilitates the safe transition of patients from one level of care to another, including home or from one practitioner to another.	The BOOST Toolkit provides a universal patient discharge checklist for all patients being discharged from the hospital to home, a general assessment of patient preparedness to be discharged, and patient transition record and discharge patient education tool to assist the care team with transition planning.	CTI formalizes the transition planning process with the implementation of a transitions care coach. The transitions care coach assists with transition planning by encouraging self-management and direct communication between patients/caregivers and primary care providers.	The TCM model facilitates transition for older patients from the hospital to the home setting. An APN meets with patients within 48 hours of discharge and then coordinates follow-up visits for them with their providers. When possible, the APN attends the follow-up visits.
Patient/Family Engagement and Education	Educating and counseling of patients and families to enhance their active participation in their own care, including informed decision making.	BOOST promotes patient education through the use of the teach-back technique. BOOST provides a video and 60–90 minute curriculum to educate the care team about the teach-back technique. BOOST also encourages the use of a DPET (Discharge Patient Education Tool)	The transitions coach works directly with the patient/caregiver to increase self-management through a hospital visit, home visit, and three follow-up phone calls. The transitions coach assists patients in asserting a more active role through care transitions by educating them on their condition, medications, patient-centered health record,	A primary role of the APN care coordinator is to educate patients and caregivers on their care. The APN discusses the care plan with patients and their family caregivers, and ensures that they understand the diagnoses, how to

Essential Elements	Description	Better Outcomes for Older Adults Through Safe Transitions (BOOST)	Care Transitions Intervention (CTI)	Transitional Care Management (TCM)
		to help patients understand the discharge instructions given to them.	follow-up care, and any indications that their condition is worsening.	identify symptoms, and when to seek follow-up care.
Communicating and Transferring Information	Sharing of important care information among patient, family, caregiver, and healthcare providers in a timely and effective manner.	The BOOST Model stresses the importance of communicating with patients using the teach-back technique and encourages information transfer from provider to patient through the use of the PASS Tool (Patient Preparation to Address Situations After Discharge Successfully). The tool is a transition record that patients leave the hospital with. Providers are encouraged to use large print, avoid medical jargon, and keep sentences short to address literacy issues.	One of the four pillars of the CTI intervention is a patient-centered record owned and maintained by the patient to facilitate cross-site information transfer. The transitions coach uses the patients' health records/portal to facilitate communication between them and their providers.	Communication is a key element of TCM. APNs develop a relationship with patients and family caregivers to ensure continuity across care. The APN also fosters communication between other members of the patient's care team, including primary care providers and specialists.
Followup Care	Facilitating the safe transition of patients from one level of care or provider to another through effective follow-up care activities.	The BOOST model stresses the importance of a post-hospitalization touchpoint to decrease hospital readmissions. The implementation guide recommends follow-up phone calls within 72 hours of discharge to identify many of the new issues and barriers patients may face after discharge.	The third of the four pillars of the CTI intervention is timely follow-up care. The transitions coach works with patients to schedule and complete follow-up visits with primary care providers or specialists.	TCM emphasizes robust follow-up care. An APN care coordinator follows up with patients in person within 48 hours of discharge from acute care. Additionally, the APN follows up with phone calls and can conduct additional in-person visits through 2–6 months post-discharge.

Essential Elements	Description	Better Outcomes for Older Adults Through Safe Transitions (BOOST)	Care Transitions Intervention (CTI)	Transitional Care Management (TCM)
Healthcare Provider Engagement	Demonstrating ownership, responsibility, and accountability for the care of the patient and family/caregiver at all times.	The model encourages provider engagement by having front-line personnel involved with the process of providing safe, effective care transitions in the hospital.	Health systems involved in CTI designate a care transitions coach, typically an APN, to assist patients in the transition process and encourage self-management.	TCM designates an APN care coordinator, who coordinates both with the patient's care team within the hospital setting and with the patient's primary and specialist providers to follow up post-discharge.
Shared Accountability Across Providers and Organizations	Enhancing the transition of care process through accountability for care of the patient by both the healthcare provider (or organization) transitioning and the one receiving the patient.	The BOOST Model encourages shared accountability by recommending the creation of a care transition improvement team to oversee the implementation of BOOST. The collaboration also includes a year of individual physician mentoring and access to an online resource center to facilitate implementation.	Not provided	The APN acting as care coordinator in TCM primarily takes responsibility for the patient's care by facilitating follow-up visits post-discharge for the patient and promoting communication between inpatient and outpatient providers caring for the patient.

POSTDISCHARGE FOLLOWUP PHONE CALL SCRIPT (PATIENT VERSION)

This form reinforces the information provided to the patient at discharge. The patient's discharge information should be available to the interviewer at the time of this call.

CALLER: Hello Mr./Ms. _____. I am [caller's name], a [type of clinician] from [name of hospital]. You may remember that when you left, the [hospital name] discharge educator, [DE name], mentioned you'd receive a call checking in on things. I am hoping to talk to you about your medical issues, see how you are doing, and see if there is anything I can do to help you. Do you mind if I ask you a few questions so I can see if there is anything I can help you with?

Is this a good time to talk? It will probably take about 15 to 20 minutes, depending on the number of medicines you are taking.

If yes, continue.
If no, CALLER: Is there a better time that I can call you back?

A. HEALTH STATUS DIAGNOSIS

CALLER: Before you left the hospital, [DE name] spoke to you about your main problem during your hospital stay. This is also called your "primary discharge diagnosis." Using your own words, can you explain to me what your main problem or diagnosis is?

If yes, confirm the patient's knowledge of the discharge diagnosis using the "teach-back" method. After the patient describes his or her diagnosis, clarify any misconceptions or misunderstandings using a question and answer format to keep the patient engaged.
If no, use this opportunity to provide patient education about the discharge diagnosis. Then conduct teach-back to confirm the patient understood.

CALLER: What did the medical team at the hospital tell you to watch out for to make sure you're o.k.?

Review specific symptoms to watch out for/things to do for this diagnosis (e.g., weigh self, check blood sugar, check blood pressure, create peak flow chart).
Measure patient's understanding of disease-related symptoms or symptoms of relapse (e.g., review diagnosis pages from AHCP).

CALLER: Do you have any questions for me about your main problem [diagnosis]? Is there anything I can better explain for you?

If yes, explain, using plain language (no jargon or medical terms).
If no, continue.

CALLER: Since you left the hospital, do *you* feel your main problem, [diagnosis], has improved, worsened, or not changed? What does your family or caregiver think?

If improved or no change, continue below.
If primary condition has worsened,

- **CALLER:** I'm sorry to hear that. How has it gotten worse? Have you spoken to or seen any doctors or nurses about this since you left the hospital?
- **If yes, CALLER:** Who have you spoken with/seen? And what did they suggest you do? Have you done that?
- Using clinical judgment, use this conversation to determine if further recommendations, teaching, or interventions are necessary.

- Record any action patient/caregiver has taken and your recommendations on the documentation sheet.

CALLER: Have any new medical problems come up since you left the hospital?

If yes:

CALLER: What has happened?

CALLER: Is there anyone else involved in your care that I should talk to?

- **If yes,** Name: _____

  Phone number: _____

CALLER: Have you spoken to anyone about this problem? Prompt if necessary: Has anyone:

- Contacted or seen PCP?
- Gone to the ER/urgent care?
- Gone to another hospital/provider?
- Spoken with visiting nurse?
- Other?
- Following the conversation about the current state of the patient's medical condition, consider recommendations to make to the caregiver, such as calling PCP, going to emergency department, etc. Record any actions and recommendations on documentation sheet.

B. MEDICINES

High Alert Medicines

Use the guide below to help monitor medicines with significant risk for adverse events.

Drug Category	What To Look For
Anticoagulants	Bleeding; who is managing INR
Antibiotics	Diarrhea; backup method of birth control Should not taken at same time as calcium and multivitamin
Antiretrovirals	Review profile for drug interactions
Insulin	Inquire about fasting blood sugar
Antihypertensives	Dizziness If yes, suggest patient space out medicines (keep diuretic in a.m.)
Medicines related to primary diagnosis	Focus on acquisition and medication adherence

Can you bring all of your medicines to the phone, please? We will review them during this call. Bring both prescription medicines and over-the-counter medicines, the ones you can buy at a drugstore without a prescription. Also, bring any supplements or traditional medicines, such as herbs, you are taking. Finally, could you also please bring to the phone the care plan that we gave you before you left the hospital?

CALLER: Do you have all of your medicines in front of you now?

CALLER: I'm going to ask you a few questions about each one of your medicines to see if there is anything I can help you with. We will go through your medicines one by one.

First of all, I want to make sure that the medicines you were given were the right ones. Then we'll discuss how often you've been able to take them and any problems or questions you might have about any of them.

Choose one of your medicines to start with.

What is the name of this medicine? The name of it should be on the label. **If the patient is using a generic,** check that he or she understands that the brand and generic names are two names for the same medicine.

- At what times during the day do you take this medicine?
- How much do you take each time?

If the patient answers in terms of how many pills, lozenges, suppositories, etc. What is the strength of the medicine? It should say a number and a unit such as mg or mcg.

- How do you take this medicine? **If there are special instructions** (e.g., take with food), probe as to whether the patient knows the instructions and whether he or she is taking the medicine as instructed.
- What do you take this medicine for?
- Have you had any concerns or problems taking this medicine? Has anything gotten in the way of your being able to take it? Have you ever missed taking this medicine when you were supposed to? Why?
- Do you think you are experiencing any side effects from the medicine?

If yes, Could you please describe these side effects?

- Are you taking any other medicines? Repeat list of questions for each medicine.
- After patient has described all medicines, ask: Are you taking any additional medicines that you haven't already told me about, including other prescription medicines, over-the-counter medicines, that is, medicines you can get without a prescription, or herbal medicines, vitamins, or supplements?

If patient has been prescribed medicines that the patient hasn't mentioned, ask whether he or she is taking that medicine.

- **If yes,** go through the list of medicine questions.
- **If not,** probe as to why not. **If patient is unaware of the medicine,** make a note to check with discharge physician as to whether patient is supposed to be taking it, whether a prescription was issued, etc.

CALLER: Have you been using the medicine calendar (in your care plan) that was given to you when you left the hospital?

If yes, provide positive reinforcement of this tool.
If no, suggest using this tool to help remember to take the medicines as directed. **If patient has lost care plan,** offer to send a new copy of AHCP by mail or email.

CALLER: Do you use a pill box?

If yes, provide positive reinforcement of using this tool.
If no, suggest using this tool to help remember to take the medicines as ordered.

CALLER: What questions do you have today regarding your medicines and medicine calendar (if using)?

CALLER: Does your family or caregiver have any questions or concerns about your medicines?

Please note on the documentation sheet any recommendation you made to the patient and followup actions you took.

C. CLARIFICATION OF APPOINTMENTS

CALLER: Now, I'm going to make sure you and I have the same information about your appointments and tests that are coming up. You were given appointments with your doctors [and for lab tests] when you left the hospital. Can you please tell me:

What is the next appointment you have scheduled?
Who is your appointment with?
What is your appointment for?
When is this appointment?
What is your plan for getting to your appointment?
Are you going to be able to make it to your appointment? Is there anything that might get in the way of your getting to this appointment?

- **If yes,** Let's talk about how we can work around these difficulties.
- **If patient plans to keep appointment, ask,** Do you have the phone number to call if something unexpectedly comes up and you can't make the appointment?
- **If patient can't keep appointment,** get the patient to reschedule: As soon as we hang up, can you call to reschedule your appointment? **If patient is unable or unwilling to make the call to reschedule,** offer to make the call: I can reschedule that appointment for you. What days and times would you be able to make an appointment? **After you get several times, say,** Thanks. I'll call you back when I've been able to set up the appointment. **If patient refuses to cooperate,** consult the DE and hospital team.
- Do you have any other appointments scheduled? **If yes,** repeat the set of questions. **If no,** but other appointments are scheduled, ask, Are you looking at the care plan? Are there any other appointments listed there? Review these appointments.

D. COORDINATION OF POSTDISCHARGE HOME SERVICES (IF APPLICABLE):

CALLER: Have you been visited by [name of service, e.g., visiting nurse, respiratory therapist] since you came home?

If no, CALLER: I will call to make sure they are coming soon.

CALLER: Have you received the [name of equipment] that was supposed to be delivered?

If no, CALLER: I will call to make sure it is coming soon.

CALLER: I understand that [name of caregiver] was going to help you out at home. Has [name of caregiver] been able to provide the help you need?

If no, CALLER: Are you going to call [name of caregiver] to see if she [or he] is going to be able to help you?

- **If no,** Is there anyone else that could help you out? Can you call [her/him] to see when [she/he] could come?

E. WHAT TO DO IF A PROBLEM ARISES

CALLER: Before we hang up, I want to make sure that if a medical problem arises, you know what to do. If you're having an emergency, for example [give disease-specific examples, e.g., chest pain, trouble breathing], what would you do?

If patient does not say, "Call 911," explain the need to get an ambulance so he or she can see a doctor right away, and confirm patient understanding.

CALLER: And what about if you [give example of urgent but not emergent problem] in the evening? What would you do then? Check if patient knows how to reach the doctor after hours. **If DE help line operates after hours,** check that the patient knows that and can find the number on the AHCP. Confirm understanding.

CALLER: And what about if you are having a medical problem that is not an emergency, such as [give disease-specific examples] and want to be seen by your doctor before your next scheduled appointment, what would you do?

If patient does not know, instruct: You can call your doctor's office directly and ask for an earlier appointment. Sometimes your doctor is very busy, so if you are having difficulty obtaining an appointment, ask if you can be seen by someone else in the office, such as a nurse, nurse practitioner, or physician's assistant. Confirm understanding.

CALLER: Just to make sure we're on the same page, can you tell me what you'd do if [create nonemergent scenario]?

If patient answers incorrectly, ask: Do you have your doctor's phone number handy? It should be on the care plan on the appointments page. **If patient can't tell you the number, say,** Let me give you the phone number for your primary care doctor just in case. Do you have a pen and paper to write this down? Do you need me to mail or email you another copy of your care plan?

- **If yes,** confirm address or email.

CALLER: Do your caregivers have these numbers also?

If no, ask: Would you like me to email or mail a copy of your care plan to them?
If yes, confirm address or email.

CALLER: That's all I needed to talk to you about. We've covered a lot of information. What questions can I answer for you?

If none, CALLER: Thank you and have a good day. If you have to follow up with patient on anything, remind him or her that you will be calling back.
If the patient has questions, answer them.

POPULATION MEASURES FOR CONDITION SPECIFIC MANAGEMENT

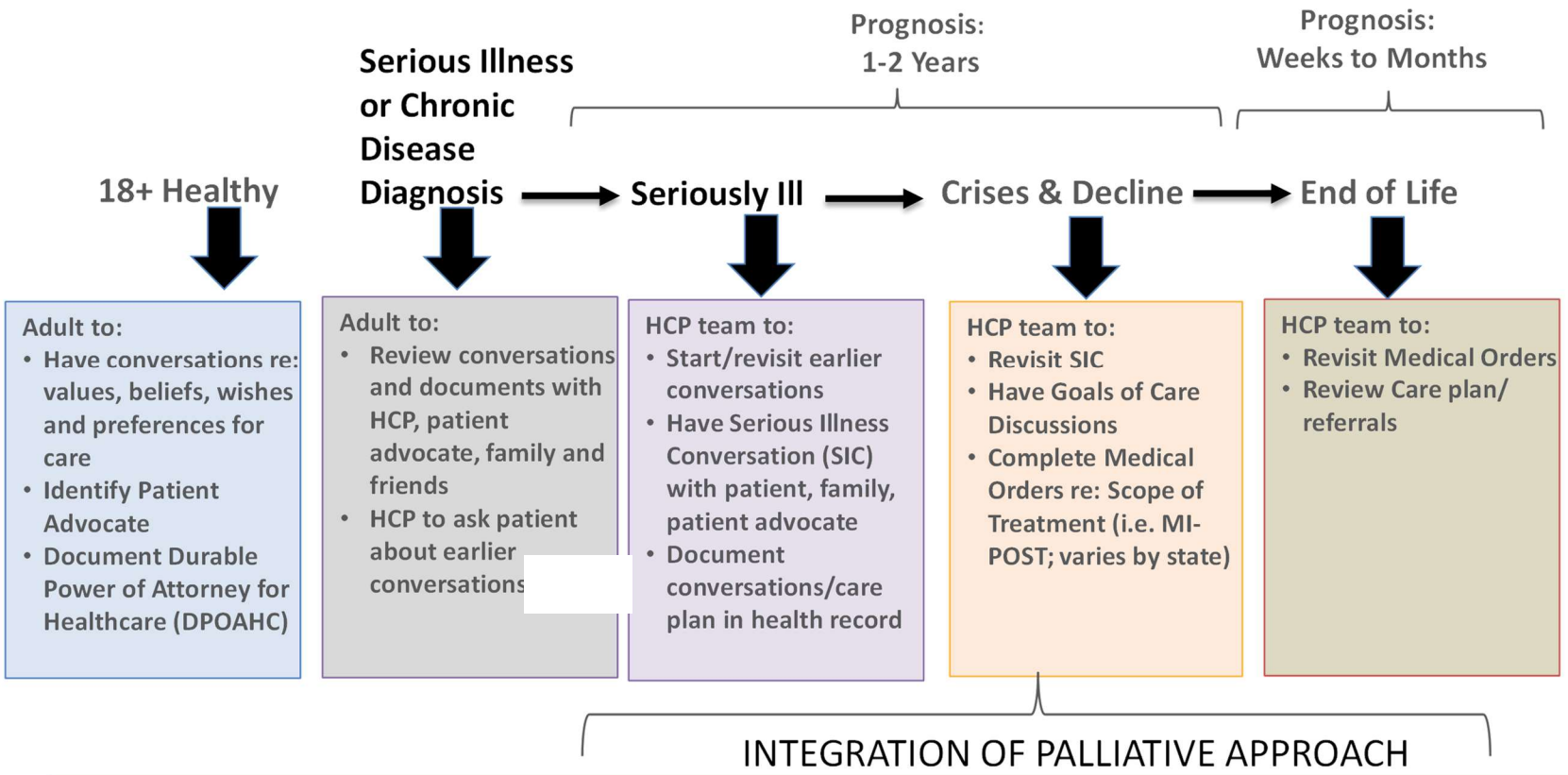
Medical Condition	Population definition (potential population)	Data Source(s)	Outcome measurement definition (goal)	Number of patients in defined population	Percentage of patients (population) at outcome measure (current state)	Number of patients screened per practice protocol	Percentage of patients that screened positive (not meeting outcome measure)	Of the percent of patients screened, the percentage that received interventions (or referrals) per protocol	For patients with interventions (or referrals), the percentage that received regularly monitoring per protocol	Percentage of patients that treatment intensification considered for patients not at target during monitoring	Percent of post intervention (or referral) patients at target	Percent of patients at outcome measure 1 year later
Diabetes Example	Individuals with diagnosis of diabetes (type 1,2 or other specific types)	Electronic medical record, coding system, lab results	Glycemic goal (A1C ≤ 5.0)	500 patients	30% (150 patients at target)	n/a	n/a	n/a	Of the 70% not at goal (350 patients) 35% received intervention or referral (122 patients)	Of the 35% (122) that received an intervention or referral 80% were monitored and considered for treatment intensification (98 patients)	Of the patients monitored (98 patients) 50% are at target (49 patients)	35% patients at or below target
Diabetes												

Medical Condition	Population definition (potential population)	Data Source(s)	Outcome measurement definition (goal)	Number of patients in defined population	Percentage of patients (population) at outcome measure (current state)	Number of patients screened per practice protocol	Percentage of patients that screened positive (not meeting outcome measure)	Of the percent of patients screened, the percentage that received interventions (or referrals) per protocol	For patients with interventions (or referrals), the percentage that received regularly monitoring per protocol	Percentage of patients that treatment intensification considered for patients not at target during monitoring	Percent of post intervention (or referral) patients at target	Percent of patients at outcome measure 1 year later
Hypertension Example	Individuals with active diagnosis of hypertension or 18 and older with a positive screen	Electronic medical record, coding system, blood pressure results	Blood pressure goal (systolic ≤ 130 or diastolic ≤ 80)	500 patients	30% (150 patients at target)	90% patients aged 18 or older had a blood pressure completed (1800 of 2000 patients)	10% not at goal (200 patients)	75% received intervention or referral (150 patients)	50% of patients with intervention or referral monitored (75 patients)	Of the 50% (75), 90% were monitored and considered for treatment intensification (68 patients)	Of the patients monitored (68 patients) 100% are at target (68 patients)	50% patients at or below target
Hypertension												

Medical Condition	Population definition (potential population)	Data Source(s)	Outcome measurement definition (goal)	Number of patients in defined population	Percentage of patients (population) at outcome measure (current state)	Number of patients screened per practice protocol	Percentage of patients that screened positive (not meeting outcome measure)	Of the percent of patients screened, the percentage that received interventions (or referrals) per protocol	For patients with interventions (or referrals), the percentage that received regularly monitoring per protocol	Percentage of patients that treatment intensification considered for patients not at target during monitoring	Percent of post intervention (or referral) patients at target	Percent of patients at outcome measure 1 year later
Depression Example	Adults and adolescents age 12 and older with active diagnosis of depression based on a positive screen (PHQ ≥10) for moderate to severe depression in the primary care setting	Electronic medical record, coding system, depression screening results	Depression goal Remission (PHQ < 5) or improvement (decreased score of 5 or more points, or a 50% improvement)	300 patients	33% (100 patients)	33% patients 12 and older had a depression screening completed (100 patients)	60% not at goal (60 patients)	75% received intervention or referral (45 patients)	33% of patients with intervention or referral monitored (15 patients)	Of the 33% (15), 67% were monitored and considered for treatment intensification (10 patients)	Of the patients monitored (10 patients) 70% are at target (7 patients)	35% patients at or below target
Depression												

Medical Condition	Population definition (potential population)	Data Source(s)	Outcome measurement definition (goal)	Number of patients in defined population	Percentage of patients (population) at outcome measure (current state)	Number of patients screened per practice protocol	Percentage of patients that screened positive (not meeting outcome measure)	Of the percent of patients screened, the percentage that received interventions (or referrals) per protocol	For patients with interventions (or referrals), the percentage that received regularly monitoring per protocol	Percentage of patients that treatment intensification considered for patients not at target during monitoring	Percent of post intervention (or referral) patients at target	Percent of patients at outcome measure 1 year later
Heart Failure												
COPD												

ADVANCE CARE PLANNING CONTINUUM



Advance Care Planning - Planning in Advance of Serious Illness
Serious Illness Care Conversation - Planning in the context of progression of serious illness
Goals of Care Discussion- Decision making in context of clinical progression/crisis/poor prognosis

BC Centre for Palliative Care Draft, 2017, Adapted from Ariande Labs