Transitions of Care from a Community Perspective

ACMA Utah Chapter 2nd Annual Education Session

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Sr. Project Manager, HealthInsight
Presenting with the 5 I’s

• Interactive
• Informal
• Imperfect
• Iterative
• Informative
Who We Are:
HealthInsight is a nonprofit, community-based health care consulting organization, working to improve health and health care for patients and providers.

What We Do:
As a neutral convener, we partner with health care providers, stakeholders and patient communities to transform care and improve care delivery and patient outcomes.
Agenda

• What is the problem and how are we doing
  – Readmission Report
• Local Interventions
  – Transitional Care Management Encounter
  – Business Process Analysis
  – Risk Predication Tools
• INTERACT: An Overview
  – Skilled Nursing Facilities
  – Home Health
• Other Activities
Defining “Preventable”, “Avoidable”, or “Unnecessary”, hospitalization is challenging because numerous factors and incentives influence the decision to hospitalize.
Fault Tree Approach to Readmissions

Readmissions

- Planned Readmission
- Against Pt. Wishes
- Complications
- Not Ready for D/C
- New Diagnosis
- Post D/C Failures
- Poorly Executed Care Transition

- Stated
- Unstated
- Revealed Post Discharged
- Appropriate Setting of Care (In vs. Outpatient)
- Known or Knowable
- Unknown or Complications
- Untreated
- Incomplete Treatment

- Transitions to Other Care Location
  - SNF
  - HHA
  - Self
  - Other

- Communication
- Care Team
- Receiving Providers
- Risk Not Recognized
- Medication Reconciliation
- Resources
- Inpractical

- Setting
- Care Team
- Patient Activation
- Education
What is the Problem, Data Discussion: The Facts
The Facts: Medicare Readmissions

• Nationally, 1 in 6 Medicare beneficiaries are readmitted within 30 days of discharge
  – Up to 76% of readmissions are from problems with care transition
  – Greater dissatisfaction with discharge compared to any other care aspect for Medicare patients
  – Avoidable hospital readmissions place a physical and emotional burden on patients and family

• UT readmission rate is 1 in 8, 17.1% lower than national average
The Facts: Medicare Readmissions

- Unnecessary readmissions cost Medicare an estimated $12 billion annually.
  - Hospitals with high readmission rates are at risk for a financial penalty
  - Penalties are capped at 1% of Medicare payments in 2013 and the cap rises to 3% by 2015
  - 2,222 hospitals penalized
The Realities of CMS Penalties

<table>
<thead>
<tr>
<th>Year</th>
<th># Penalized</th>
<th>Range:</th>
<th>UT Avg</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2013</td>
<td>2</td>
<td>0 - 0.29%</td>
<td>0.01%</td>
</tr>
<tr>
<td>FY 2014</td>
<td>6</td>
<td>0 - 0.29%</td>
<td>0.02%</td>
</tr>
<tr>
<td>FY 2015</td>
<td>14</td>
<td>0 - 2.02%</td>
<td>0.29%</td>
</tr>
</tbody>
</table>

*Note: UT Avg refers to the Utah Average penalty rate.*
SNFs with the highest rankings receive the highest incentive payments and SNFs with a zero or low ranking will receive the lowest incentive payments.

- Effectively, the lowest 40% of SNFs will be reimbursed less than they otherwise would in the absence of this program.

To fund the payment pool, CMS will withhold 2% of SNF Medicare payments starting October 1, 2018.

- CMS will then redistribute 50-70% of the withhold back into to SNF's by way of incentive payments

CMS will keep the balance, 30-50% as savings to Medicare.
# 30 Day Readmission Rate: Percentage

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>DELTA COMMUNITY MEDICAL CENTER</td>
<td>0.5% (0.17)</td>
</tr>
<tr>
<td>MILFORD VALLEY MEMORIAL HOSPITAL</td>
<td>0.5% (0.3)</td>
</tr>
<tr>
<td>OREM COMMUNITY HOSPITAL</td>
<td>0.5% (0.3)</td>
</tr>
<tr>
<td>SANPETE VALLEY HOSPITAL - CAH</td>
<td>3.2% (1.31)</td>
</tr>
<tr>
<td>THE ORTHOPEDIC SPECIALTY HOSPITAL</td>
<td>4.2% (6.143)</td>
</tr>
<tr>
<td>BEAR RIVER VALLEY HOSPITAL</td>
<td>4.8% (1.21)</td>
</tr>
<tr>
<td>BRIGHAM CITY COMMUNITY HOSPITAL</td>
<td>6.3% (4.64)</td>
</tr>
<tr>
<td>SEVIER VALLEY MEDICAL CENTER</td>
<td>7.1% (6.85)</td>
</tr>
<tr>
<td>CASTLEVIEW HOSPITAL</td>
<td>7.3% (13.177)</td>
</tr>
<tr>
<td>LONE PEAK HOSPITAL</td>
<td>8.0% (4.50)</td>
</tr>
<tr>
<td>TIMPANOOGS REGIONAL HOSPITAL</td>
<td>8.1% (10.123)</td>
</tr>
<tr>
<td>PARK CITY MEDICAL CENTER</td>
<td>8.5% (8.90)</td>
</tr>
<tr>
<td>AMERICAN FORK HOSPITAL</td>
<td>9.2% (24.261)</td>
</tr>
<tr>
<td>MOUNTAIN VIEW HOSPITAL</td>
<td>9.7% (21.216)</td>
</tr>
<tr>
<td>LAKEVIEW HOSPITAL</td>
<td>10.0% (29.291)</td>
</tr>
<tr>
<td>MCKAY DEE HOSPITAL</td>
<td>11.0% (109.991)</td>
</tr>
<tr>
<td>SAN JUAN HOSPITAL</td>
<td>11.1% (5.45)</td>
</tr>
<tr>
<td>GARFIELD MEMORIAL HOSPITAL</td>
<td>11.4% (4.35)</td>
</tr>
<tr>
<td>ALTA VIEW HOSPITAL</td>
<td>11.9% (22.186)</td>
</tr>
<tr>
<td>JORDAN VALLEY MEDICAL CENTER</td>
<td>12.0% (48.399)</td>
</tr>
<tr>
<td>SALT LAKE REGIONAL MEDICAL CENTER</td>
<td>12.1% (26.214)</td>
</tr>
<tr>
<td>ASHLEY REGIONAL MEDICAL CENTER</td>
<td>12.2% (9.74)</td>
</tr>
<tr>
<td>LDS HOSPITAL</td>
<td>12.3% (42.342)</td>
</tr>
<tr>
<td>State of Utah</td>
<td>12.5% (1.252/12.241)</td>
</tr>
<tr>
<td>GUNNISON VALLEY HOSPITAL</td>
<td>12.5% (9.72)</td>
</tr>
<tr>
<td>VALLEY VIEW MEDICAL CENTER</td>
<td>12.7% (28.221)</td>
</tr>
<tr>
<td>MOAB REGIONAL HOSPITAL</td>
<td>12.7% (7.150)</td>
</tr>
<tr>
<td>RIVERTON HOSPITAL</td>
<td>12.7% (14.110)</td>
</tr>
<tr>
<td>DIXIE REGIONAL MEDICAL CENTER</td>
<td>12.8% (219.1.635)</td>
</tr>
<tr>
<td>DAVIS HOSPITAL AND MEDICAL CENTER</td>
<td>13.0% (41.316)</td>
</tr>
<tr>
<td>UTAH VALLEY REGIONAL MEDICAL CENTER</td>
<td>13.1% (137.1.048)</td>
</tr>
<tr>
<td>UNIVERSITY HEALTH CARE/UNIV HOSPITALS AND CLINICS</td>
<td>13.1% (1.47/1.408)</td>
</tr>
<tr>
<td>INTERMOUNTAIN MEDICAL CENTER</td>
<td>13.8% (215.1.633)</td>
</tr>
<tr>
<td>LOGAN REGIONAL HOSPITAL</td>
<td>14.1% (31.220)</td>
</tr>
<tr>
<td>UINTAH BASIN MEDICAL CENTER</td>
<td>14.1% (11.78)</td>
</tr>
<tr>
<td>ST MARKS HOSPITAL</td>
<td>14.2% (127.897)</td>
</tr>
<tr>
<td>MOUNTAIN WEST MEDICAL CENTER</td>
<td>14.8% (18.1.22)</td>
</tr>
<tr>
<td>OGDEN REGIONAL MEDICAL CENTER</td>
<td>14.9% (65.368)</td>
</tr>
<tr>
<td>CACHÉ VALLEY HOSPITAL</td>
<td>15.0% (9.60)</td>
</tr>
<tr>
<td>FILLMORE COMMUNITY MEDICAL CENTER</td>
<td>15.0% (3.20)</td>
</tr>
<tr>
<td>HEBER VALLEY MEDICAL CENTER</td>
<td>17.4% (4.23)</td>
</tr>
<tr>
<td>CENTRAL VALLEY MEDICAL CENTER - CAH</td>
<td>17.9% (15.84)</td>
</tr>
<tr>
<td>BLUE MOUNTAIN HOSPITAL</td>
<td>20.0% (41.35)</td>
</tr>
<tr>
<td>BEAVER VALLEY HOSPITAL</td>
<td>22.2% (2.67)</td>
</tr>
<tr>
<td>KANE COUNTY HOSPITAL</td>
<td>26.3% (5.19)</td>
</tr>
</tbody>
</table>

Sum of Readmission Rate for each Hospital. Color shows details about State Rate. Color: The marks are labeled by sum of Readmission Rate, sum of Denominator and sum of Nominator. Details are shown for State. The data is filtered on Qtr End Date (MY), which keeps March 2015. The view is filtered on State, which keeps UT.
30 Day Readmission Rate: Scatter Plot

Sum of Denominator vs. sum of Readmission Rate. Color shows details about scatterplot color. Size shows sum of Denominator. The marks are labeled by Hosp Name. Details are shown for Hosp Name. The data is filtered on State and Qtr End Date (MY). The State filter keeps UT. The Qtr End Date (MY) filter keeps March 2015.
Readmission Pattern: Statewide, Discharge Site

- **HHA**
  - Readmission Rate: 14.2%
  - Number of Quarterly Discharges: 2,079

- **SNF**
  - Readmission Rate: 13.9%
  - Number of Quarterly Discharges: 3,153

- **Home**
  - Readmission Rate: 12.4%
  - Number of Quarterly Discharges: 5,134

- **Hospice**
  - Readmission Rate: 0.3%
  - Number of Quarterly Discharges: 315
30 Day Readmission Pattern

Days to Readmission for Hospital Discharges, 2015

[Bar chart showing the number of discharges over days for 30-day readmissions, with a peak around 1-5 days and a steady decline thereafter.]
Characteristics of a Patient Readmitted to a Hospital within 30 Days of Discharge

- **Gender**: Male
- **Age**: 70.6 years
- **Dual Eligible**: Yes
- **Index Admission LOS**: 4.7 days
- **Most common D/C Status**: Home
- **Avg. Claim**: $33,818

- **DRGs**: Septicemia, Sepsis, Joint Replacement, HF
- **Common Diagnosis**: ESRD, Acute Kidney Failure
- **Readmission**: Metabolic Disorder, Dehydration
CMS Coordination of Care Objectives

Ambitious goals, such as these, demand a community-based approach:

• Reduce 30 day Readmissions: 10%
• Reduce Admissions: 2%
• Increase Community Tenure: 2%
• Reduce Adverse Drug Events: 35%
SOCIAL FACTORS
- Level 1 - Sociodemographic: Age, Gender, Race
- Level 2 – Socioeconomic: Education, Income, Insurance, Martial Status, Employment
- Level 3 - Environment:
  - Social: Social Support, Housing Situation
  - Behavioral: Medication, Diet, Visit Adherence, Substance Abuse, Smoking
  - Socialcognitive: Health Literacy, Language Proficiency
  - Neighborhood: Urban/Rural, Proximity to Health Care, Community Poverty

CLINICAL FACTORS
- Disease Severity, Comorbidities, Vitals, Labs, Functional Status

PROVIDER FACTORS
- Specialty Experience, Cultural Competence, Communication Skills

SYSTEM FACTORS
- Availability of Inpatient / Outpatient Services, Health Policy

OUTCOMES
- Readmissions
- Morbidity
- Mortality
- Costs (Personal and Systemwide)

PROCESS OF CARE
- Inpatient Care
- Discharge Coordination
- Post D/C Outpatient Management
Interventions Using a Community Based Approach
Community Selection

- Referral Patterns represented by **Blue Arrows**
- Existing and/or target cohort communities are in **Red**
- Many counties that are “rural” or “frontier” - results in low numbers
- Total screening required in UT: 13,400
Intervention Package

• Local Interventions
  – Standardized Information on Transfers
  – “Look Up” Rights for Partners
  – Risk Predication Tools
  – Business Process Analysis

• INTERACT – SNF and Home Health
  – Verbal Reporting
  – Medication Reconciliation
  – Discharge Summaries
**Discharge Risk Assessment**  (to be completed 2 days prior to discharge)

### PATIENT NAME:

<table>
<thead>
<tr>
<th>CHECK ALL THAT APPLY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lives at home with limited or no community support</td>
</tr>
<tr>
<td>Requires assistance with medication management</td>
</tr>
<tr>
<td>Polypharmacy (greater than 7 medications)</td>
</tr>
<tr>
<td>History of mental illness</td>
</tr>
<tr>
<td>Issues with health literacy</td>
</tr>
<tr>
<td>Requires assistance with ADL's/ADL's</td>
</tr>
<tr>
<td>Cognitive impairment</td>
</tr>
<tr>
<td>End stage condition*</td>
</tr>
<tr>
<td>Diagnosis of CHF/COPD/diabetes/HIV/AIDS</td>
</tr>
<tr>
<td>Incontinent</td>
</tr>
<tr>
<td>Acute/chronic wound or pressure ulcer</td>
</tr>
<tr>
<td>History of falls</td>
</tr>
<tr>
<td>Decreased adherence to treatment plan</td>
</tr>
<tr>
<td>Repeat hospitalizations/ED visits</td>
</tr>
<tr>
<td>Requires assistance in management of Oxygen and/or nebulizer</td>
</tr>
</tbody>
</table>

**TOTAL # CHECKED =**

<table>
<thead>
<tr>
<th>SCORE ≥ 5</th>
</tr>
</thead>
</table>
This patient is **HIGH RISK** for rehospitalization. Refer to home care services immediately.

<table>
<thead>
<tr>
<th>SCORE of 2 – 4</th>
</tr>
</thead>
</table>
This patient is at **MODERATE RISK** for rehospitalization. Refer to home care prior to discharge.

<table>
<thead>
<tr>
<th>SCORE &lt; 2</th>
</tr>
</thead>
</table>
This patient is **LOW RISK** for rehospitalization. Discharge to community.

**TO QUALIFY FOR MEDICARE HOME HEALTH SERVICES:**

- The patient is under the care of a physician (community physician willing to sign home care orders).
- The patient requires skilled nursing, physical therapy, or speech therapy services; or has a continuing need for occupational therapy on an intermittent basis. (If daily, then there is an endpoint to daily care.)
- Services are provided in the patient’s home.
- Services must be reasonable and necessary.
- The patient is homebound.

### DEFINITION OF HOMEBOUND:

Homebound means the condition of the patient causes a considerable and taxing effort for the patient to leave home.

### Homebound Qualifiers:

- Absences from the home are infrequent or of short duration

Examples of infrequent or short duration absences:

- Attendance at religious service
- Attendance at a significant family event
- Trip to barber or hairdresser
- Walk outdoors

- To receive health care treatment
- To receive medical day care services

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**REFER TO HOME HEALTH SERVICES FOR:**

**SKILLED NURSING**

- Observation & assessment
- Teaching & training
- Performance of skilled treatment of procedure

**AND/OR**

- Physical, occupational and/or speech therapy
- Medical social work
- Home health aide service for personal care and/or therapeutic exercises
- Telehealth Care Management

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**Hospice patients need not be homebound**

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This material was produced by EQ Health Solutions, The Medicare Quality Improvement Organization for Louisiana, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. LA155662C12 2020.
BPA FUNCTIONAL ANALYSIS

• How do you work a 1000 piece jig saw puzzle?
  Step #1: __________________           
  Step #2: __________________           
  Step #3: __________________           
  Step #N: __________________           

• How do you know when you’re done?

• What does it mean if there are still “holes” in the puzzle?

• What does it mean if you have “extra” pieces when there are no “holes” left?
Hospital Discharge Business Process

- Social Workers
- Nurses
- Pharacy
- Intake
- Hospitalist

- A.A.
- Program A
- Program B
- Billing
- Hosp Adm

- Hospital Discharge Business Process Work Flow

- SNF’s
- PROG. A
- PROG. B
- LTAC
- Insurance

- Business Partner
- House Keeping

- D1
- D2
- C1
- C2
- A1
- A2
- B1
- B2
- A3
- A4
- B3
- B4
Utah Valley Regional Medical Center: Discharge to Home, Context Diagramming. Ver. 1.3 - Draft
What is INTERACT?
A substantial proportion of hospitalizations of nursing home (NH) residents may be avoidable. Medicare payment reforms, such as bundled payments for episodes of care and value-based purchasing, will change incentives that favor hospitalization but could result in care quality problems if NHs lack the resources and training to identify and manage acute conditions proactively. Interventions to Reduce Acute Care Transfers (INTERACT) II is a quality improvement intervention that includes a set of tools and strategies designed to assist NH staff in early identification, assessment, communication, and documentation about changes in resident status. INTERACT II was evaluated in 25 NHs in three states in a 6-month quality improvement initiative that provided tools, on-site education, and teleconferences every 2 weeks facilitated by an experienced nurse practitioner. There was a 17% reduction in self-reported hospital admissions in these 25 NHs from the same 6-month period in the previous year. The group of 17 NHs rated as engaged in the initiative had a 24% reduction, compared with 6% in the group of eight NHs rated as not engaged and 3% in a comparison group of 11 NHs.

The average cost of the 6-month implementation was $7,700 per NH. The projected savings to Medicare in a 100-bed NH were approximately $125,000 per year. Despite challenges in implementation and caveats about the accuracy of self-reported hospitalization rates and the characteristics of the participating NHs, the trends in these results suggest that INTERACT II should be further evaluated in randomized controlled trials to determine its effect on avoidable hospitalizations and their related morbidity and cost.

Goals of INTERACT

• Improve care, not prevent all hospital transfers
• Support quality of care and resident outcomes as organizations try to manage more complex patients
• Promote improvement to “the way things are done”
  – INTERACT is a quality improvement program
    • Implementation supports QAPI requirements
What is INTERACT

Using the INTERACT Tools
In Every Day Care

- New Resident Admission
  - Resident Re-Assessment
- Change in Resident Status Noted
  - CNA, Other Direct Care Staff, or Family Alerts LPN/RN
  - LPN/RN Evaluation
  - MD/NP/PA Notified
- Acute Care Transfer
- Medication Reconciliation Worksheet
- Stop and Watch Early Warning Tool
- SBAR Form and Progress Note
- Transfer Checklist Envelope
- Transfer Data List and Sample Forms
- Quality Improvement Program
  - Apply learning to improve care processes and education

Patient Flow
INTERACT Tools
Community
QI/QA Tools
Medication Reconciliation

Patient Transfer and Medication Reconciliation Worksheet

Part 1: Report Information
Admission Date: __/__/____ Hospital Name: __________________________

Did you receive a verbal report from the transferring facility? Yes □ No □
If Yes, How was the verbal report made? The hospital notified you □ You notified the hospital □

Did you receive a completed discharge summary from the transferring facility? Yes □ No □

Part 2: Hospital Discharge Medication Orders Needing Clarification*

<table>
<thead>
<tr>
<th>Name and category of medication needing clarification</th>
<th>Clarification Needed</th>
<th>Resolution (Stop, Start, Change, Etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticoagulants: □ Opioids: □ Diabetic Agent: □ Antipsychotics: □ Other: □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anticoagulants: □ Opioids: □ Diabetic Agent: □ Antipsychotics: □ Other: □</td>
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</tr>
</tbody>
</table>

Part 3: Medication Prior to Hospitalization Needing Clarification*

<table>
<thead>
<tr>
<th>Name and category of medication needing clarification</th>
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</tr>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Residents Name: __________________________

*Examples: unclear diagnosis or indication, uncertain dose or route of administration, stop date, hold parameters, lab tests needed for monitoring, dose different than before hospitalization, medication duplication
Implementation Materials
INTERACT in the Community

- Medication Screenings to reduce ADEs
- Nurse Reporting (Warm Handoffs)
- Readmission patterns by sign/symptom and presumed diagnosis
- Common transfer forms
- Capabilities checklists
- Encourage Community Participation
  - HealthScape
Local Data: Med Rec, Verbal Reports
Patients needing clarification: 3,604 (27%)

Medication categories:
- Antipsychotics: 227
- Anticoagulants: 462
- Opioids: 761
- Diabetic Agents: 588
- MedCatOther: 4,538

Completed discharge:
- 1 medication issue in any category: 3,603
- 2 medication issues in any category: 1,690
- 3 or more medication issues in any category: 747

Percentage of patients needing clarification over time:
- June 2015: 48%
- July 2015: 47%
- August 2015: 45%
- September 2015: 44%
- October 2015: 43%
- November 2015: 42%
- December 2015: 41%
- January 2016: 40%
- February 2016: 39%
- March 2016: 38%
- April 2016: 37%
- May 2016: 36%
- June 2016: 35%
- July 2016: 34%
- August 2016: 33%
### Analysis and Feedback are Timely

#### Patient Transfer and Medication Reconciliation Worksheet

**Part 1: Report Information**
- Admission Date: __/__/____
- Hospital Name: __________

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**Part 2: Hospital Discharge Medication Orders Needing Clarification**

<table>
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<td>Anticoagulants: ☐</td>
<td>Opoids: ☐</td>
<td>Diabetic Agents: ☐</td>
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**Part 3: Medication Prior to Hospitalization Needing Clarification**

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<td>Opoids: ☐</td>
<td>Diabetic Agents: ☐</td>
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<td>Diabetic Agents: ☐</td>
</tr>
<tr>
<td>Anticoagulants: ☐</td>
<td>Opoids: ☐</td>
<td>Diabetic Agents: ☐</td>
</tr>
</tbody>
</table>

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**Residents Name:**
*Example: cancer, diagnosis or indication, uncertain data or route of administration, stop data, hold parameters, lost*
HealthScape: Ensuring an Equal Playing Field
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HealthScape: Ensuring an Equal Playing Field
Additional Activities
Office Based Activities

- Transitional Care Management
- Chronic Care Management
- Diabetes Education (Central Health District)
- Annual Wellness Visit
- QI Training (SNF, HH)
Home or Patient Based Activities

- Teach Back
- Health Literacy
- Cultural Competency
- Care Transitions Intervention (Coaching)
  - SUU, CON
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