

**Empowering Care Oregon Patients: Enhancing Care Transitions with a New
Communication Tool**

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Abstract (Word count: 250/250)

The transition of care (TOC) period delineates the timeframe during which patients transition from one level or realm of care to another, playing a pivotal role in their journey from illness to health, and in the overall resource utilization within the healthcare system. This TOC period is significantly influenced by patients' own understanding of their role in managing their health and by the impact of social determinants of health (SDOH). These factors add complexity and challenges to the TOC process. This quality improvement project concentrated on the TOC period following hospital discharge from an academic hospital in Oregon. There, a team of healthcare professionals was established to support vulnerable Medicaid patients, significantly affected by SDOH (e.g., health insurance coverage, health literacy), in transitioning from hospital discharge to establishing care with a primary care provider. By conducting root-cause analyses and engaging in interviews with team members, several communication barriers were identified within a specific cohort of Medicaid patients. Subsequently, a communication tool was developed to address these barriers. The aim of the project was to create a communication tool that would be both practical and feasible for the TOC team to integrate into their practice. After multiple iterations/refinements, the tool was presented to the team, followed by conducting a post-survey. The survey results showed that the tool was feasible and useful for working with the specific cohort of Medicaid patients. Further research should explore the effects of implementing this tool on patient's post-discharge health management and on reducing hospital readmission rates.

Empowering Care Oregon Patients: Enhancing Care Transitions with a New Communication Tool

Problem Description

Transition of care (TOC) is described as the period when a patient is between levels of medical care (Rochester-Eyeguokan et al., 2016). This constitutes reduction in care acuity, change in care location, or discharge from the inpatient care system to the community. TOC is a critical period in the patient's healing process, and is impacted by numerous factors including delay in post-discharge follow-up, patients' non-adherence to the therapeutic plan, and social determinants of health (SDOH) (Shah et al., 2020). SDOH such health insurance coverage, access to medical care/medications, health literacy, and housing instability impact how, where, and when patients can access their care (Shah et al., 2020), thus TOC programs must take all of these factors into consideration to be successful.

Poorly executed care transitions can lead to reduced patient safety (Englander et al., 2014), increased risk of hospital readmission, and more frequent Emergency Department (ED) visits (Englander et al., 2014; Shah et al., 2020). Poorly coordinated TOC also leads to a significant economic burden. In 2018, out of the total 3.8 million hospital readmissions within 30 days, 80% were Medicare and Medicaid patients (Weis & Jian, 2021). This finding suggests that Medicare and Medicaid have a high readmission rate, possibly due to poorly coordinated TOC.

Moreover, the efficiency of care transitions directly impacts hospital bed availability, a critical aspect of healthcare access. Currently the Pacific Northwest is at 76% inpatient bed occupancy, slightly above the national average of 73% (Centers for Disease Control & Prevention [CDC], 2023). The Hospital Readmissions Reduction Program created by the Affordable Care Act in 2010, was created to decrease the burden of 30-day readmission (Zuckerman et al., 2016). In 2010, a TOC program was developed at an urban academic medical center in Oregon; the program consists of two different teams who plan post-discharge

care for patients in the ED and inpatient units. The ED TOC team works with patients who frequently utilize emergency services with the intent to promote connection and coordination with outpatient care. The Inpatient TOC team specifically focuses on Medicaid patients who are being discharged from the hospital but require close follow-up due to either complex medical care needs or a high-risk for readmission. This team's focus is to establish a successful transition of these Medicaid patients into stable primary outpatient care. This team sees patients with two types of public insurance, both of whom are heavily impacted by SDOH. The first group has fewer care coordination issues because their insurance is serviced solely by the health system through which the TOC team works, leading to easier communication and a uniform Electronic Health Record (EHR). For patients of the alternative insurer (Care Oregon), the target population of this quality improvement (QI) project, there is increased difficulty with various aspects of care coordination due to the fragmentation of EHR. Specifically, for patients under Care Oregon, primary care providers (PCPs) cannot always easily access patients' charts. Additionally, communication between the TOC team and PCP offices is reported to be challenging and patient care tends to become decentralized, resulting in increased patient responsibility for follow-up care after discharge.

To gain a deeper understanding of barriers the targeted group encounter while establishing care with PCPs, a root-cause analysis (Appendix A), was performed individually with different members of the TOC team. Through this process, we learned that patients experience prolonged wait times for appointments, have difficulty communicating with their PCPs by phone, and have difficulty understanding the next steps in their care after discharge. The TOC team reviews discharge instructions with patients, but after-visit summaries (AVSs) are complicated and any additional information is given verbally. Further, this population of patients typically has limited experience with primary and preventative care. The TOC team attends most PCP intake appointments with these patients after they are discharged from the hospital. From their experience, patients frequently express confusion regarding who their PCPs

are, and are not fully aware of the appropriate steps to take in case of care complications or when to seek further care. Aside from an AVS, patients do not have a good written alternative to access the information regarding next steps in their care.

Discussion with the TOC team, informed by the root-cause analysis findings, suggest that a written communication tool for patients to have information regarding their post-discharge care would be the best way to mitigate the coordination difficulties due to the fragmentation of the EHR. The literature supports the involvement of patients in their care and suggests counseling patients with written transition tools that patients can repeatedly refer when necessary (Agency for Healthcare Research and Quality [AHRQ], 2013; Rochester-Eyeguokan et al., 2016). Medicaid patients (particularly, those under Care Oregon) and the TOC team would benefit from a written communication tool for patients that aids in a successful transition from the hospital setting to the primary care setting.

Available Knowledge

While there is no standard consensus or guideline for TOC best practice, there has been much research on what constitutes effective transitions (Hewner et al., 2021; Rochester-Eyeguokan et al., 2016). A review by Rochester- Eyeguokan et al. (2016) found that successful TOC services are multimodal, multidisciplinary and begin well before discharge. Importantly, there must be close collaboration between inpatient and outpatient services, and it is crucial for patients to actively engage in their care (Rochester-Eyeguokan et al., 2016).

The National Transitions of Care Coalition (NTOCC) is an independent organization focused on the development, innovation, and evaluation of TOC services. The NTOCC has outlined seven essential intervention categories that TOC should include: medication management, transition planning, healthcare provider coordination and engagement, patient and family engagement/education, information sharing, patient follow-up, and shared accountability across providers. These seven categories align well with the AHRQ, a division of the U.S. Department of Health and Human Services, Re-Engineered Discharge (RED) Toolkit

(AHRQ, 2013). The RED Toolkit facilitates patient involvement with their care by using written discharge plans discussing their diagnoses and medicines (AHRQ, 2013). Additionally, plans should be set in case a problem arises and patients should be continuously assessed to ensure understanding of the discharge plan. The RED toolkit was initially evaluated in a randomized trial of 738 patients discharged from Boston Medical Center (Hume et al., 2012). In Hume et al. (2012), the intervention group received education, personalized discharge coordination, and pharmacist follow-up in accordance with RED standards. Patients in the control group, on the other hand, underwent the usual care discharge process. Compared to the control group, the intervention group had a 30% lower rehospitalization rate and lower use of the emergency department within the first 30 days after discharge. Patients in the intervention group were also reported to be more likely to identify their diagnosis, understand their medications, and follow up with their PCP.

While there is evidence that the RED toolkit can be a successful TOC tool (AHRQ, 2013; Hume et al., 2012; Rochester-Eyeguokan et al., 2016), the degree of success with TOC tools, like RED, is variable (Rochester-Eyeguokan et al., 2016). Rochester-Eyeguokan et al. (2016) reported that some studies which utilized multimodal interventions modelled after Project RED, had similar success rates in hospital readmission compared to standard discharge processes, while others showed no significant difference after the Project RED implementation (Rochester-Eyeguokan et al., 2016). Results like this may reflect the challenges around implementing TOC programs and the nuances involved with different patient populations. There may be also socioeconomic and environmental factors (such as SDOH) complicating hospital discharge that are difficult to identify through research. One study conducted with uninsured and Medicaid patients, found no change in hospital readmission post-intervention (Englander et al., 2014). The authors cited numerous factors that may have contributed to this null finding, some of which were related to the complexity of care for these patients and the lack of research on best TOC practices for this population.

Additionally, much of the research on this topic is focused on quantitative outcomes and does not reflect the patient experience through the transition. One qualitative study of patient experiences with a Project RED discharge tool reported that while study participants found the tool an improvement to typical discharge instructions, information regarding how, when, and from whom to access post discharge care was still unclear (Horstman et al., 2017). Qualitative studies can be particularly valuable in identifying the reasons behind the variability in success rates among TOC programs or in comprehending the factors contributing to the diverse success rates observed during the implementation of TOC programs.

Thus, while toolkits such as those provided by the NTOCC and Project RED serve as useful guidelines, the implementation of multimodal interventions can vary significantly depending on the site and stakeholders involved. Therefore, it is critical to identify the most appropriate intervention, tailor existing interventions, or create an effective communication tool to best suit the needs of the Medicaid patients the TOC team serves.

Rationale

The Model for Improvement (MFI) framework, supported by the Institute for Healthcare Improvement (IHI) (n.d.) was utilized to identify a QI aim, measures for monitoring improvement, and the changes necessary to result in improvement. Through the completion of a root-cause analysis diagram, the TOC team identified the barriers that contribute to Care Oregon patients having difficulty establishing care with their PCP after hospital discharge. One identified and potentially modifiable barrier was patients' lack of understanding of how, when, and where to utilize their PCP. Due to the structure of their insurance provider (Care Oregon), these patients experience increased fragmentation of care, placing greater responsibility on them to access these necessary services.

To promote patient understanding of their resources post discharge and to promote involvement with accessing them, a communication tool was developed. The tool went through

plan, do, study, act (PDSA) cycles. The TOC team identified a problem and planned for a response to the problem with the development of a communication tool. After the development of the tool, it was presented to the inpatient TOC team for review and amendment, ensuring its applicability to Care Oregon patients and their specific needs in receiving appropriate TOC.

Specific Aims

The aim of this QI project was to evaluate the TOC team's perceived utility and feasibility of a communication tool developed for their Care Oregon patients. Given that Care Oregon patients face increased responsibility in managing their own healthcare and encounter more challenges with communications, the project aimed to enhance communication between the TOC team and these patients. The expected outcome was the development of a communication tool for enhancing communication between the TOC team and these Care Oregon patients, leading to improved access to healthcare services and a reduction in readmission rates.

Context

The Inpatient TOC team consists of three Registered Nurses (RN), one Social Worker (SW), and one Family Nurse Practitioner (FNP). The TOC team members work with patients as they prepare for discharge and through the transition to community phase, lasting approximately 30 days. Their patients are usually referred to their services through different care providers within the same institution. The Inpatient TOC team cares for patients with two different types of Medicaid insurance, who are typically medically complex, at high risk for readmission, and affected by SDOH such as housing insecurity. Limited health literacy, another SDOH, also plays heavily into the work of the TOC team and their efforts to support patients.

The Inpatient TOC team assists with finding care for patients, organizing appointments, and assisting with finding additional services that patients may need or benefit from after discharge. Any information communicated about this from the Inpatient TOC team to patients is given verbally, only at one time, challenging the ability to retain this information. The patient still has a full responsibility to understand their needs and how to access their healthcare to promote

independence and prepare for disengaging from the TOC team's services. These factors collectively contribute to increased communication challenges between the TOC team and these Medicaid patients.

Interventions

Through discussions with the TOC team and a root-cause analysis, supported by the literature reviewed above, we determined that developing a communication tool to facilitate effective communication with the TOC team is the first step toward promoting a better understanding of post-discharge care and access to PCP healthcare services. Numerous communication tools have been created to improve the TOC process for patients. The IHI has compiled some of these tools (Rutherford et al., 2013); this compilation was used for reference to identify pertinent discussion points and to create a prototype communication tool for the inpatient TOC team that could later be altered to fit the teams' needs.

In accordance with PDSA cycles, there were multiple steps in the creation of this communication tool. In cycle 1, a patient communication tool in the structure of a double-sided form was developed containing space for the TOC team to fill out information to review with the patient such as reason(s) for hospitalization, reasons to go to their PCP and emergency room, issues to review with the PCP, and who their new medical team would be. This information was deemed important by the Inpatient TOC team RNs who were initially interviewed during the root-cause-analysis. Contents of the tool is also supported by the literature review to be pertinent information for patients to have during the TOC process. After creation of the tool, it was introduced to one RN on the inpatient TOC team. Verbal feedback on the tool including readability for the patient and content from the TOC RN was gathered and used to revise the tool. The introduction of this tool to one team member allowed for a collaborative and inclusive process for developing a tool more tailored to the TOC team's needs. In cycle 2, the revised tool was introduced to all five team members in the inpatient TOC team, including the initial RN. An anonymous survey was administered on 10/23/2023 via email and open for two weeks, to

gauge the rest of the TOC team's perceived utility and feasibility of the tool. In cycle 3, the TOC's collective feedback was used to create a finalized patient communication tool.

Measures

The primary goal of this project was to evaluate the perceived utility and feasibility of the communication tool within the TOC team. Data pertaining to this evaluation was acquired through an anonymous survey, as outlined in Appendix B. There was a total of four qualitative and quantitative questions, two of which had sub-questions left as text boxes for further commentary. Quantitative questions were presented on a five-Likert scale ranging from 'extremely unlikely' to 'extremely likely'. The survey, initially set for two weeks, was extended by an additional week to facilitate the participation of a targeted goal of five team members.

Analysis

The data analysis followed a two-step process. First, preliminary verbal feedback from the RN was obtained during a 30-minute meeting focused on evaluating the content and readability of the communication tool. This feedback was then used to revise the communication tool. Second, the revised communication tool was presented to the TOC team, and anonymous surveys assessing its perceived utility and feasibility were distributed via a web-based platform (Qualtrics, 2020). Quantitative data from the survey were entered in Microsoft Excel for analyses. Because of the small team size (only five members), we conducted descriptive statistics (frequency and mean) on the quantitative data, and responses to open-ended questions (qualitative data) provided crucial insights for further modifications to the communication tool.

Ethical Considerations

This QI project was approved by the Institutional Review Board at OHSU and deemed non-human research prior to implementation. Additional ethical considerations include maintaining volunteer anonymity, despite the challenges posed by the small TOC team size. Secure handling of data was ensured as the data were collected using an OHSU verified survey

platform, safeguarded by OHSU encryption, user passwords, and a two-factor authentication system.

Results

During the initial feedback session, the TOC RN proposed the inclusion of space for listing medications, Red Flag symptoms to seek care, and information regarding a transportation service available to Medicaid patients; thus, the tool was revised to add this information.

Afterwards, the revised tool and surveys were disseminated and completed by four out of the five TOC team members.

Utility of the Communication Tool: Results of the survey (Appendix C) show that when asked how likely the team thought the communication tool would assist with improving patient's awareness of post-hospital discharge instructions, reasons to seek further medical care, from whom to seek further care, and where to seek further care, all four respondents answered 'likely' (on a 5-point Likert scale). When asked about patients understanding how to contact their care offices three respondents answered 'likely', one response was ranked as 'neither unlikely nor likely'. When asked how likely the tool would improve communication regarding post-discharge care, one respondent answered 'neither unlikely nor likely', while the remaining three voted it to likely improve.

Feasibility of the Communication Tool: Three respondents said that they would likely incorporate this tool into their practice, while one said they were extremely likely to do so.

Qualitative data from open-ended questions indicate that the tool could be valuable as a multi-page booklet, enhancing portability for patients. One respondent mentioned that the form served as a commendable starting point, allowing the team to expand upon it, particularly for more complex patients requiring additional explanations of care.

Discussion

The development of this communication tool aimed to support the TOC team's work and promote better utilization of primary care by patients. The findings of the surveys suggest that the communication tool is both feasible and beneficial for integration into the practice of this TOC team. Insights from the RN interview and qualitative data finding suggests a preference for a pocket-sized format, although maintaining the tool's content within such constraints poses challenges. The suggestion of adopting a booklet format emerges as a potential resolution to this issue.

The strengths of this project lie in its adaptability, as the tool was tailored to the unique patient population, rendering it more pertinent to the team's specific work to care for Medicaid patients. Medicaid patients are more likely to perceive a lack of respect from their care providers, often stemming from perceived discrimination (Ghabowen & Bhandari, 2021). These perceptions by patients results in worse patient-providers relationships, compromised access to care, lower quality of care, and reduced compliance with care plans. It is expected that using a communication tool developed for Medicaid patients may provide an opportunity to improve the care experience of this vulnerable population.

Limitations

The team's small size enhanced the likelihood of quick acknowledgement and incorporation of individual feedback into the revision process. However, this also presents challenges, as the small sample size, without a deep dive approach, may potentially limit the scope and depth of feedback, potentially overlooking diverse patients' needs and priorities. Further, the qualitative feedback from the online survey was limited, suggesting that more comprehensive methods such as 1:1 interviews or focus groups could have provided deeper insights. Although these methods were initially considered, the logistical challenges of coordinating team members for simultaneous interviews, given their interdependent work schedules, made this approach impractical. Finally, the specific design and content of the tool

for this team may limit its generalizability to other TOC teams within the institution or beyond, reducing its broader relevance.

Interpretation

Responses from the survey reveal that the TOC team believes the communication tool is likely to contribute to improved communication with patients and patient understanding of their healthcare, including resources available to them and how to access these resources. This is in alignment with existing research previously reviewed stating that tools focused on the TOC period can improve patient understanding of their health status (AHRQ, 2013; Hume et al., 2012; Rochester-Eyeguokan et al., 2016). While this tool may not directly reduce hospital readmissions on its own, it can play a significant role in preventing readmissions. Further research is warranted to explore the effects of implementing this communication tool on patient's post-discharge health management and on reducing hospital readmission rates. Additionally, feedback from the teams shows that they believe the tool may also help patients understanding of when, how and from whom to access their health, a gap previously identified in the literature (Horstman et al., 2017).

Conclusions

Overall, the creation of a communication tool was identified to be useable and feasible for the TOC team for which it was made. The tool has been given to the team digitally so that it can be revised as necessary or preferred by each team member. Future implications for this tool include creating the communication tool in a booklet format and assessing the implementation of the tool within the TOC team's workflow. Additionally, evaluation of the tool by the Medicaid patients and primary care providers seeing these patients would identify if the tool is not only perceived to be useful and feasible but if it results in improved communication and eventually use of outpatients services.

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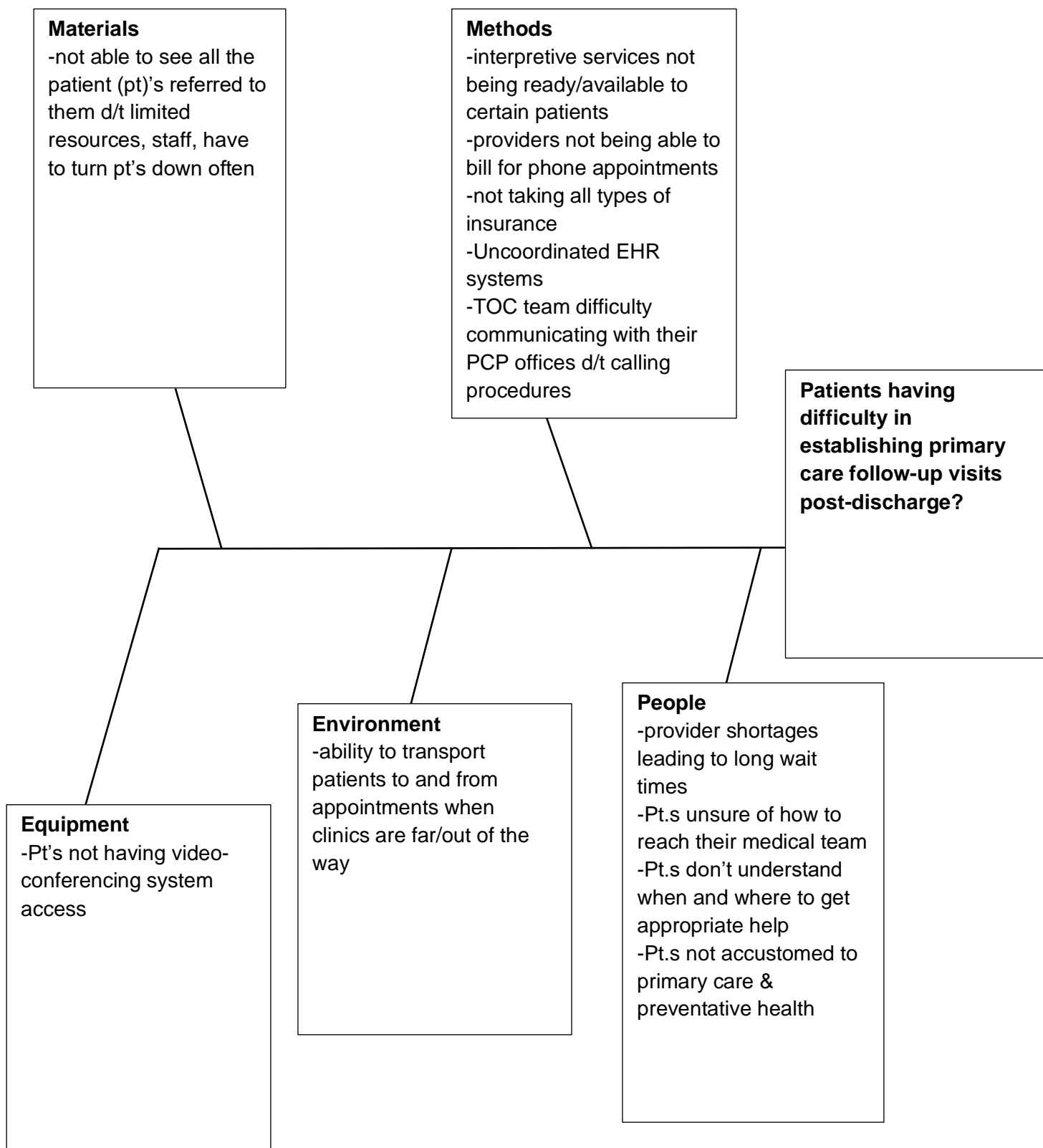
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Appendix A. Root-cause Analysis



Appendix B. Survey Questionnaire



Survey description: The aim of this QI project is to understand your perceptions on the utility of the communication tool and feasibility of incorporating it into your practice. We value your input and plan to use it to further develop this tool. Please take a moment to answer the following questions. Your participation is greatly appreciated.

Q1. How likely do you think this communication tool will help with the following aspects after patients being discharged from the hospital? Please rate each aspect on a scale from 1 to 5, with 1 being 'extremely unlikely' and 5 being 'extremely likely.'

	Extremely Unlikely	Unlikely	Neither Unlikely or Likely	Likely	Extreme Likely
Patients being aware of the appropriate steps (e.g., taking medications, wound management) to take in terms of their care after hospital discharge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patients being aware of when to seek further care once discharged	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patients knowing of whom to seek further care from after hospital discharge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patients knowing where their care offices are located	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patients knowing how to contact their healthcare providers after hospital discharge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (please specify)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>					

Please rate on a scale from 1 to 5, with 1 being 'extremely unlikely' and 5 being 'extremely likely:'

Q2. How likely do you think this communication tool will improve communication with your patients regarding their post-discharge care?

Extremely Unlikely	Unlikely	Neither Unlikely nor Likely	Likely	Extremely Likely
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q2A. (If you responded neither likely or unlikely, unlikely, or extremely unlikely [in Q2]) Do you have any suggestions to improve communication with your patients by using this tool?

Q3. How likely are you to incorporate this tool into your current practice?

Extremely Unlikely	Unlikely	Neither Unlikely nor Likely	Likely	Extremely Likely
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q3A. (If you responded neither likely or unlikely, unlikely, or extremely unlikely [in Q3]) Do you have any suggestions to improve the feasibility of incorporating this tool into your current workflow?

Q4. Do you have any other additions or modifications of the content or layout that you would like to see in the communication tool?

We thank you for your time spent taking this survey.

Your response has been recorded.

Appendix C. Survey Results

Post-Intervention Survey Responses

Q1. How likely do you think this communication tool will help with the following aspects after patients being discharged from the hospital? Please rate each aspect on a scale from 1 to 5, with 1 being 'extremely unlikely' and 5 being 'extremely likely.'

	Average	n=4
Patients being aware of the appropriate steps (e.g., taking medications, wound management) to take in terms of their care after hospital discharge	4	
Patients being aware of when to seek further care once discharged	4	
Patients knowing of whom to seek further care from after hospital discharge	4	
Patients knowing where their care offices are located	4	
Patients knowing how to contact their healthcare providers after hospital discharge	3.75	

Q2. How likely do you think this communication tool will improve communication with your patients regarding their post-discharge care?

	Responses	n=4
Extremely Unlikely	0	
Unlikely	0	
Neither Unlikely nor Likely	1	
Likely	3	
Extremely Likely	0	

Q3. How likely are you to incorporate this tool into your current practice?

	Responses	n=4
Extremely Unlikely	0	
Unlikely	0	
Neither Unlikely nor Likely	0	
Likely	3	
Extremely Likely	1	

Q4. Do you have any other additions or modifications of the content or layout that you would like to see in the communication tool?

Response A: I feel the second page is spot on and useful, especially as a reminder for some of our more forgetful patients, it's also a good segue into teaching them how to access care and services (Ride to Care, etc.). I feel it likely will need expansion for some of our medically complex folks, but I think this is a great baseline. I can also see it being useful a living document, not unlike a "nurse brain", that we can update and print out for them.

Response B: If it could be multiple pages like a small booklet, that might be easier for them to keep on their person.

Response C: I can see it benefitting both provider and client. Well done.

Appendix D. Letter of Support from Clinical Agency

Letter of Support from Clinical Agency

Date: 07/20/2023

Dear Francine Olney,

This letter confirms that I, Rachel Prusak, allow Francine Olney (OHSU Doctor of Nursing Practice Student) access to complete his/her DNP Final Project at our clinical site. The project will take place from approximately August 2023 to December 2023.

This letter summarizes the core elements of the project proposal, already reviewed by the DNP Project Preceptor and clinical liaison (if applicable):

- **Project Site(s):** Care Transitions and Innovations Team (C-TraIn), Oregon Health and Science University, 3181 SW Sam Jackson Park Rd, Portland, OR 97239
- **Project Plan:**
 - **Identified Clinical Problem:** Through the completion of a root-cause-analysis diagram, the C-TraIn team identified the barriers that contribute to Care Oregon patients having difficulty establishing care with their PCP after hospital discharge. One identified and potentially modifiable barrier was patients' lack of understanding of how, when, and where to utilize their PCP.
 - **Rationale:** Currently, information regarding next steps in care is discussed by the C-TraIn team with patients verbally. To promote patient understanding of their resources post-discharge and to promote their involvement in accessing them, a communication tool to be used during the transition of care (TOC) should be developed.
 - **Specific Aims:** The aim of this QI project is to evaluate C-TraIn's perceived utility and feasibility of a communication tool developed for their Care Oregon patients. The expected outcome of this project is improved communication between C-TraIn and these Care Oregon patients and eventually, better access to services.
 - **Methods/Interventions/Measures:** There will be multiple steps to create this communication tool. First, a patient communication tool in the form of a card will be developed based on the root-cause-analysis completed by the DNP student/a C-TraIn team RN, combined with evidence from the literature review. Second, after creating the tool, it will be introduced to one RN on C-TraIn. Verbal feedback on perceived utility and feasibility from the RN will be gathered and used to revise the tool. Third, the revised tool will be introduced to the other team members of C-TraIn. After the team members have access to the tool for two weeks, an anonymous survey will be administered to gauge the rest of the team's perceived utility and feasibility. Finally, C-TraIn's collective feedback will be used to create a finalized patient communication tool.
 - **Data Management:** Data will be collected solely at the clinic from the C-TraIn's team (No patient information will be included). The surveys will be anonymously administered through a web-based platform (Qualtrics), an OHSU approved survey platform ensuring the confidentiality of the data. Any data gathered for the purposes of the project will not be associated with any identifiable information and will be managed via the OHSU encrypted, password-protected, and protected by a two-factor authentication system.
 - **Site Support:** The DNP Project preceptor agrees to be in contact with the student regarding meeting times as necessary to conduct the project. The study site will allow the student to present revisions of the tool to C-TraIn during

designated meeting times and support the survey to be distributed to C-TraIn team.

During the project implementation and evaluation, *Francine Olney* will provide regular updates and communicate any necessary changes to the DNP Project Preceptor.

Our organization looks forward to working with this student to complete their DNP project. If we have any concerns related to this project, we will contact *Francine Olney* and *Dr. Minkyong Song* (student's DNP Project Chairperson).

Regards,

DNP Project Preceptor (Name, Job Title, Email, Phone):

Signature

Date Signed

Appendix E: IRB Letter of Determination



IRB MEMO

Research Integrity Office

3181 SW Sam Jackson Park Road - L106RI
Portland, OR 97239-3098
(503)494-7887 irb@ohsu.edu

NOT HUMAN RESEARCH

August 3, 2023

Dear Investigator:

On 8/3/2023, the IRB reviewed the following submission:

Title of Study:	Empowering Care Oregon Patients: Enhancing Communication in the Transition of Care Process with a New Communication Tool
Investigator:	MinKyoung Song
IRB ID:	STUDY00026079
Funding:	None

The IRB determined that the proposed activity is not research involving human subjects. IRB review and approval is not required.

Certain changes to the research plan may affect this determination. Contact the IRB Office if your project changes and you have questions regarding the need for IRB oversight.

If this project involves the collection, use, or disclosure of Protected Health Information (PHI), you must comply with all applicable requirements under HIPAA. See the [HIPAA and Research website](#) and the [Information Privacy and Security website](#) for more information.

Sincerely,

The OHSU IRB Office

