ED Care Triage for At-Risk Populations: Primary Care Linkage (for Adult Medical and Pediatric EDs)
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Implementation Toolkit: ED Care Triage- Primary Care Linkage

**HOW TO USE THIS IMPLEMENTATION TOOLKIT**

**INTENDED AUDIENCE**

This toolkit is intended to be used by the **Emergency Department (ED) Care Triage Workgroup** in hospitals within the OneCity Health Performing Provider System (PPS) network. This workgroup is further detailed in subsequent sections, and includes the essential clinical, administrative, health information technology and other individuals critical to the successful implementation of this project. The toolkit may also be used by any other hospital staff who play a role in this project.

The ED Care Triage project focuses on the Adult Medical and Pediatric EDs.

**STRUCTURE**

This toolkit presents a five competency framework for assessment of primary care linkage. Using this five competency framework as a starting point, the project workgroup for the ED Care Triage project will assess current processes for primary care linkage, identify areas for improvement (“gaps”), identify systems-based obstacles or resource gaps, and implement a plan for process improvement.

*This toolkit will focus on Primary Care Linkage in the ED. A separate toolkit focuses on Care Management in the ED.*

**PROJECT OVERVIEW**

**PROJECT OBJECTIVE**

The objectives of the ED Care Triage project, as reflected in state-defined metrics, are to:

- Reduce hospitalizations and ED visits,
- Increase primary care linkage; and
- Support care coordination.

**PROJECT DESCRIPTION**

The ED Care Triage project aims to improve the care of patients who are treated and released from the ED. Patients may have a variety of needs upon discharge from the ED, ranging from a large proportion of patients who require primary care follow-up appointments, to a smaller group of high-risk patients who need care management (CM) services.

To reflect this variety of needs, the ED Care Triage project is comprised of two different, but related, subprojects:
Project 1: Primary Care Linkage

**Goal:** To obtain primary care appointments for ED patients at a clinically appropriate time interval, for all patients who require primary care follow-up.

Project 2: ED Care Management (EDCM)

**Goal:** To reduce hospitalizations and ED revisits by providing targeted, short-term care management (CM) services for ED patients at risk of unsuccessful transitions to community-based care.

The **ED Care Triage** project includes the Adult and Pediatric EDs. Facilities will need to decide whether to carry out work separately or in close collaboration across these settings. Where workflows differ, facilities may find it most practical to create separate workgroups for each of these three settings. Facilities may decide to focus initial implementation on these settings and subsequently expand.

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**THIS INITIATIVE DOES NOT PROMOTE REDIRECTION**

There is an optional program component in the DSRIP state metrics for the ED Care Triage project related to point-of service redirection of patients in the ED to primary or urgent care. **This OneCity Health initiative is not promoting redirection of patients from the ED.** All patients who present to the ED will be seen in the ED and receive standard care. The goal of the ED Care Triage project is to link patients, before they are discharged from the ED, to primary care and in later project phases, to care management, as needed. This will ultimately impact future utilization patterns.

**ED CARE TRIAGE PROJECT 1: PRIMARY CARE LINKAGE**

The goals of the primary care linkage include:

- To ensure that primary care follow-up appointments are made for all patients who have a clinical need for one on discharge from the ED;
- To ensure that the process of making these appointments supports high-quality linkage, defined as linkage that respects existing continuity relationships of the patient with a primary care practice; that identifies new primary care resources for patients without prior primary care providers; and that promotes patient attendance at follow-up appointments;
- To build collaborative relationships with primary care providers in order to improve the linkage process, both within and outside the ED’s own facility.

Successful linkage of ED patients to primary care depends on improved processes both in the ED and in the primary care settings. **This toolkit focuses on work that can be done within the ED care setting.**
FIVE COMPETENCY FRAMEWORK FOR ASSESSMENT OF PRIMARY CARE LINKAGE

This toolkit uses the following five competencies as a framework to assess and improve the quality of the primary care linkage.

1. Correctly identify the patient’s primary care provider (PCP)
2. Determine at what time interval the appointment should be made
3. Communicate the correct provider and time interval to the scheduler
4. Schedule the appointment and document that it was made
5. Communicate the appointment information and provide key clinical information to patient

Using this five competency framework as a starting point, the Project Workgroup for the ED Care Triage project will assess current processes for primary care linkage, identify areas for improvement (“gaps”), identify systems-based obstacles or resource gaps, and implement a plan for process improvement.

Over a two to three month period, the Project Workgroup should plan to select two or three priority areas for improvement to focus on first. Over a six to twelve month period, the Project Workgroup should plan to implement standard workflows that will address areas of improvement across all five competencies in this framework. Each facility – and potentially each ED setting (adult and pediatric) will have different areas of strengths and weaknesses. Therefore, each facility’s Project Workgroup will need to prioritize which areas to address over time.

We anticipate that Project Workgroups will identify obstacles to providing high-quality primary care linkage in most or all of the five competencies in this framework. Some obstacles will be specific to the facility and best-addressed with local solutions. Other obstacles may be system-wide problems, require additional resources, or may raise problems that are facility-based but for which the Workgroup cannot find a solution. **We strongly encourage the Workgroup to identify obstacles that are not addressable at the local facility level and raise these obstacles to the OneCity Health team.** OneCity Health and the Workgroup will then explore opportunities to (1) leverage experience of other partner sites who may have found solutions to similar problems, (2) address key resource gaps, and/or (3) advocate to fix system-wide problems.

ONECITY HEALTH SUPPORT DESK

If you have any questions, please contact the OneCity Health support desk:

Phone Number: 646-694-7090
Email: ochsupportdesk@nychhc.org, with the subject line “ED Care Triage Question”

**Hours of Operation:** Monday through Friday from 9am to 5pm ET

### STEP 1: PREPARE TO IMPLEMENT IMPROVEMENTS FOR PRIMARY CARE LINKAGE

#### Establish Project Workgroup

**Establish an ED Care Triage Workgroup:** This workgroup is responsible for key tasks, such as mapping workflows, identifying training needs, supporting implementation, and quality improvement. The ED Care Triage project includes the Adult and Pediatric EDs. Facilities will need to decide whether to carry out work separately or in close collaboration across these three settings. Where workflows differ, facilities may find it most practical to create separate workgroups for the two setting. Facilities may decide to focus initial implementation on one setting and subsequently expand to the other.

ED Care Triage Workgroup(s) should include essential clinical, administrative, health information technology and other individuals who will be critical to successfully implementing this project. Consider representatives from these stakeholder groups:

- ED Clinical staff
- ED Nursing staff
- ED Administrative staff
- Staff from Primary Care Clinics
- Care Management (e.g., Health Home)
- Social Work
- Care Coordination
- Case Management
- Finance
- IT
- Quality Improvement (QI)
- Patient Safety

**Implementation Leader:** Identify an implementation leader to oversee implementation of this project. This role can be filled by the DSRIP Facility Lead. The role of the implementation leader may include (but is not limited to) the following tasks:

- Engaging with clinical, nursing, and administrative leadership to coordinate implementation of project requirements
- Providing progress updates and reports to Facility Leadership and OneCity Health
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- Identifying workgroup members and facilitating meetings to accomplish goals
- Establishing updated workflows for meeting best practices
- Collaborating with OneCity Health to access support, training and materials for implementation
- Establishing and executing training plan, as needed
- Monitoring implementation and escalating roadblocks to facility leadership and OneCity Health, as needed

Clinical Champion(s): A clinical champion must excel in engaging, leading, and representing care teams in the facility-level implementation. The role of the clinical champion may include (but is not limited to) the following tasks:

- Engaging and advocating for implementation with clinical, nursing, and administrative leaders
- Working closely with the facility lead on education and training of care teams
- Helping clinical, nursing, and administrative staff to identify tools and resources needed to be successful
- Advising the team on improving project implementation design

Understand how Primary Care Linkage is Documented at your ED Site

Most of this toolkit will focus on improving the quality of primary care linkage – i.e., ensuring the appointment respects continuity relationships, is at the correct time interval, and is communicated appropriately to the patient.

OneCity Health will centrally collect information on the number of primary care appointments scheduled for reporting to the New York State Department of Health. While the individual facilities are not responsible for collecting this information locally, understanding the number of primary care appointments that are being made at your ED site and how/where work is being documented are critical to identifying gaps and areas for improvement. The number of appointments made is a useful quality metric for your program, as it will allow you to see what proportion of your ED patients are receiving primary care appointments before discharge. Understanding the number of primary care appointments will require the workgroup to:

- Determine how primary care appointments are tracked in your ED (EMR/EHR, scheduling system, Excel, paper, etc.)
- Determine which of the following data are available in the relevant tracking system(s): patient name (first, last), patient medical record number (MRN), Medicaid Client Identification Number (CIN), ED visit date, appointment date.
If you have no tracking system for primary care appointments that your ED is making, OneCity Health will explore ways to help you create a system. This system will be important for improving quality of linkage as well as for documenting the number of appointments.

**Develop Current and Target-state Workflows for Primary Care Linkage**

To improve the quality of primary care linkage, the Project Workgroup first needs to assess current processes – including written standard work and workflows.

- Gather written standard work for primary care linkage at your ED site
- Map the current workflow for primary care linkage at your ED site
- Identify areas for improvement (“gaps”)  
- Identify obstacles to achieving the target-state workflow
- Design, test, and implement a target-state workflow that supports higher-quality primary care linkage at your ED

In designing current and target-state workflows and in mapping key obstacles, the Workgroup should specifically address each of the following elements of primary care linkage according to the five competency framework detailed in the next section.

**A FIVE COMPETENCY FRAMEWORK FOR ASSESSMENT OF PRIMARY CARE LINKAGE**

1. Correctly identify the patient’s primary care provider (PCP)
2. Determine at what time interval the appointment should be made
3. Communicate the correct provider and time interval to the scheduler
4. Schedule the appointment and document that it was made
5. Communicate the appointment information and provide key clinical information to patient

**1. Correctly Identify the Patient’s Primary Care Provider (PCP)**

The questions below are suggested to help guide the Workgroup’s development of a baseline assessment of this competency.

The questions below are suggested for the baseline assessment.

1. Do ED staff routinely ask whether a patient has a primary care provider (PCP)?
2. Which ED staff (roles or names) are responsible for determining the patient’s primary care provider (PCP) and the PCP’s contact information?
3. For patients without a primary care provider:
   - Do ED staff member(s) routinely identify a primary care provider (PCP) to receive patient for follow-up appointment?
   - Which ED staff (roles or names) are responsible for this work?

4. Is the patient’s primary care provider (PCP) routinely documented or updated in the EHR or elsewhere? If yes, please specify.

5. How is information on the patient’s primary care provider (PCP) communicated to the scheduler?

6. **CHALLENGES:** Are there challenges your facility faces in identifying the patient’s primary care provider (PCP)?

   There may be multiple sources of information for who is the correct primary care provider, and these sources may conflict. We strongly suggest that the ED ensure that its standard algorithm for determining the correct primary care provider is consistent with other protocols within the same institution for assignment of primary care provider. The steps listed below are consistent with the algorithm used by the NYC Health + Hospitals Call Center.

   1. The primary care provider is determined by considering the following items in priority sequence:
      a. *Patient’s stated provider* – this must be assessed as information in the EMR may be incorrect. When patients identify community-based primary care providers or other providers outside the ED’s own hospital system, this relationship must be respected.
      b. *Provider listed as continuity provider* (if information is available in EMR)
      c. *Provider last seen for a routine visit* (if information is available in EMR or from the patient)

   When a specific provider is not available for the follow-up appointment in the desired time frame, on a day and time acceptable to the patient, then an appointment may be made with another member of that provider’s team, or with any other provider at that provider’s site.

   Patients whose primary care provider is not accurately reflected on the insurance card should be counseled to contact the insurance company in order to correct this.
2. Determine Time Interval for Primary Care Appointment

All patients for whom a primary care appointment is clinically necessary should leave the ED with an appointment scheduled, and only patients for whom a primary care appointment is clinically necessary should be scheduled for one.

Primary care appointments at very short time intervals are a limited resource. Every patient who requires a primary care appointment at a short time interval deserves to receive one. However, some patients are equally well served, or better served, by a primary care appointment at a longer time interval. Other patients may not actually need to see a primary care physician at all, and some might need to see a specialist.

Some sites currently have a practice of assigning primary care appointments to all patients upon ED discharge, regardless of clinical necessity. This should be discouraged, as it is detrimental to overall access, results in an increased no-show rate, and makes it difficult or impossible for some patients who truly need an appointment in a short follow-up window to get one.

Primary care sites rely on ED teams to determine the appropriate time interval for follow-up. In the absence of this step, the primary care sites may not successfully meet the needs of patients who truly need short-interval appointments.

1. How is it determined whether a patient needs a follow-up appointment and which ED staff (roles or names) make that determination?

2. Do ED staff indicate the appropriate timeframe for primary care follow-up appointment (e.g., 48-hours, 7 days, and 14 days)?

3. If yes, by what process is the timeframe selected (e.g., clinical judgment) and by which ED staff (roles or names)?

4. How is this timeframe communicated to the scheduler?

5. **CHALLENGES:** Are there challenges your facility faces in determining whether a primary care appointment is needed and in determining the appropriate timeframe for primary care follow-up appointment?

The guidelines below were developed based on existing work on this topic and guidance from subject matter experts at Lincoln and Bellevue. All patients discharged from the ED with the diagnoses below should be scheduled for a follow-up appointment within a maximum of 14 days. If a shorter timeframe is determined to be clinically necessary by the physician, it should be indicated for the scheduler. This list only includes diagnoses that specifically require
primary care follow-up (not follow-up in other ambulatory care clinics). In the future, we may consider defining primary care more inclusively, and expanding it to include other clinic codes, such as geriatrics and women’s health. We are currently working to operationalize these conditions below through ICD10 codes.

Abnormal Labs or Radiology

Asthma/COPD (patient hasn't been to Pulm Clinic)

Chest Pain with DM/HTN

CHF Treated and released

DM, poorly controlled

HTN>160/100

Lower Respiratory infection

Pyelonephritis

DVT

In order to support target-state workflow, consider the following solutions:

- Embed the above guidance (or similar guidance) into ED documentation
- Educate clinicians and other ED staff on the above guidelines
- Update written standard work or workflows, as needed
- Develop plan to monitor and reinforce processes over time
  - Consider monitoring patterns of appointment requests

3. Communicate Name of Provider and Time Interval to Scheduler

The questions below are suggested for the baseline assessment.

1. Who is responsible for communicating visit information to the scheduler?

2. How is information on the patient’s primary care provider (PCP) communicated to the scheduler (electronically, paper, etc.)?

3. CHALLENGES: Are there challenges your facility faces in communicating the primary care provider and visit interval to the scheduler?
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As part of its ongoing work, OneCity Health is requesting that primary care sites within the OneCity Health PPS network provide periodic information on whether they have new patient capacity. This information will be shared with the ED once it is available.

OneCity Health will work with PPS primary care sites to improve access, supported by primary care contracting strategy (promoting evening and weekend hours and open access scheduling), and will update and share a network assessment detailing PPS primary care and urgent care capacity, including night, weekend, same day appointments, and low/sliding scale options for the uninsured.

4. Schedule and Document Appointment

The questions below are suggested for the baseline assessment.

1. Do ED staff routinely schedule follow-up appointments in primary care? Which ED staff (roles or names) do this work?

2. Prior to scheduling a follow-up appointment, do ED staff routinely check whether the patient already has a scheduled appointment in primary care?

3. What does the scheduler do if a patient’s primary care provider (PCP) cannot be reached for scheduling or cannot offer an appointment within the appropriate timeframe?

4. What is done if the scheduler does not have the PCP’s contact information?

5. Is scheduling completed before the patient leaves the ED? Under what circumstances is scheduling completed after the patient leaves the ED?

6. Are scheduled follow-up appointments routinely documented? How/where? (e.g., EHR, electronic scheduling system, electronic or paper log).

7. **CHALLENGES:** Are there challenges your facility faces in scheduling and documentation of primary care appointments in the ED?

8. Does your ED routinely alert primary care providers (PCPs) when their patients visit your ED?

9. Do all primary care providers (PCPs) receive alerts? If no, please provide information on which PCPs do and do not receive alerts.

10. Do you use automated alerts (e.g., Encounter Notification System) or non-automated methods (e.g., phone call, fax)?
11. Is the follow-up appointment scheduled electronically? What system(s) are used, and do they vary based on PCP?

12. Does the scheduling system indicate that the appointments were made/ referred from ED (e.g., by using specially-designated appointment slots or by naming the scheduler)

*For all of the above questions, important consideration should be given to how the process varies based on the patient’s insurance status, whether the patient has a PCP, whether the PCP is at the same facility or not, and by day/time (e.g., nights, weekends)*

The goal should always be for the patient to leave the ED with their appointment scheduled and in hand, as opposed to receiving a follow-up call the day (or days) after discharge.

The ED Care Triage project is closely linked to issues of primary care appointment access, including shortage of appointments. This toolkit addresses work that can be accomplished within the ED setting. Improved workflows in the ED may help to alleviate primary care appointment access issues. For example: determining and communicating the correct time interval for the primary care appointment, making appointments with the patient’s correct primary care provider, and clearly communicating the appointment information to the patient may all begin to alleviate primary care appointment access issues.

While the ED has a role to play, it is clear that primary care access issues cannot be solved by the ED alone. To further support primary care access, OneCity Health is also supporting ongoing access improvement work that is being carried out in the primary care setting.

OneCity Health is assessing its provider network to identify Urgent Care capacity. While it is preferable for patients to see their primary care providers in order to maintain continuity and address chronic health problems, Urgent Care is a second-choice option that may help patients avoid unnecessary repeat ED visits, should they be unable to access their primary care providers.

5. Communicate Appointment Information to Patient

Primary care linkage is only useful if patients attend the appointments. Clear communication to the patient about the appointment is necessary.

1. How is the appointment information communicated to the patient?

2. How does communication of visit information to the patient differ for appointments scheduled before the patient leaves the ED vs. scheduled after the patient leaves the ED?
3. Who is responsible for contacting the patient the next day if the appointment is scheduled after they leave the ED?

4. **CHALLENGES:** Are there challenges your facility faces in communicating appointment information to the patient?

**OTHER CONSIDERATIONS FOR IMPROVING WORKFLOWS FOR PRIMARY CARE LINKAGE**

We encourage facilities to use the five competencies as a framework to assess and improve workflows for primary care linkage.

There are additional components of successful primary care linkage that have not been addressed in detail in this toolkit. After improving workflows on the five competencies in the framework, facilities should consider the following opportunities for ongoing process improvement:

- Counseling patients as to the importance of primary care follow-up using techniques such as motivational interviewing
- Ensuring that the patient and primary care provider receive clinical information and test results from the ED visit
- Using IT systems to send ‘alerts’ to primary care providers when their patients are seen in the ED

**STEP 2: DEVELOP THE INTERVENTION**

**GOALS FOR INTERVENTION DEVELOPMENT**

The main goals of this intervention development stage are:

1. Select priorities for process improvement
2. Identify facility-level solutions
3. Identify resource gaps
4. Identify systems-level barriers

**Select Priorities for Process Improvement at your Site**

The comparison of current workflows and target-state workflows will likely raise multiple areas for process improvement.

- Review areas for process improvement and choose which ones to focus on first.
- Draft a 6-month plan to detail how key process improvement areas will be addressed over that time.
As the Workgroup gains experience in this project, the target-state workflow, the prioritized process improvement areas, and the strategies for achieving improvements may evolve over time.

**Identify Facility-level Solutions**

- Propose solutions that promote process improvement and that can be feasibly designed and implemented by the Workgroup within your ED.

**Identify Resource Gaps**

- Identify any key resource gaps in staffing and/or equipment that are important for successful primary care linkage
- Identify any training needs for your staff to accomplish successful primary care linkage

Examples of trainings may include reeducating physicians on referral guidelines if it is currently common practice to refer all patients for appointments regardless of clinical necessity, or educating schedulers on the use of a new electronic form or template to schedule appointments, or a new resource guide with contact information for community physicians.

**Identify Systems-level barriers**

Systems-level barriers are barriers that transcend the ED setting and may be difficult to address at the level of the facility’s ED. Examples of systems barriers are limitations of the Electronic Health Record; difficulty reaching call centers or primary care sites to schedule appointments; inability to obtain correct contact information for community providers; or recalcitrant problems with primary care access.

- Describe major systems-level barriers to optimal primary care linkage

**DELIVERABLES**

The Implementation Lead is responsible for compiling the following and submitting to OneCity Health:

- Resource gap analysis
- Selection of 2-3 priority areas for Improvement
- Improvement Plan

The improvement plan will form the basis of the work of the workgroup.

The OneCity Health team will collaborate with each site to review their baseline assessment and gap analysis with proposed solutions, and to identify 2-3 priority areas for improvement.
For each of these priority areas, in order to assess the implementation of changes your site makes to strengthen primary care linkage for patients presenting to the ED, OneCity Health recommends completing a Plan-Do-Study-Act (PDSA) template pre and post implementing the solution. Based on your results, you may choose to modify your workflows and make any necessary adjustments based on your results and staff feedback. Please see Appendix C for an example and more information. The sample is a guide. Your individual PDSA cycles will vary based on what your site identifies as priority areas for improvement.

If your site prefers to use a different improvement tool to measure change and success, that is acceptable.

**BEST PRACTICES**

The goal of the ED Care Triage project is to improve care for patients treated and released from the ED. The first of the subprojects focuses on improving linkages to primary care in the ED. Thus far, 12 best practices have been identified among the three pilot hospitals. *Please refer to the attached Best Practices Guide that details these recommendations.*

While completing the baseline assessment, consider the five competencies, outlined above, across different EDs and various patient subgroups. Workflows will vary, depending on where patient groups receive primary care.

1. **Segment the population to understand what’s driving the themes you’re seeing and stratify patients when initiating an intervention**: There may be challenges that only affect some groups. If your hospital does not have capacity to make appointments for all patients in the ED, consider targeting one segment of the population first.

2. **Select target areas for improvement based on where you are most likely to move the needle now**: Success during Phase 1 is more likely if the site can determine where it is possible to make an impact with existing resources, and to focus energy there first.

3. **Be incremental in your approach**: In addition to mapping a “target state” workflow, one hospital opted to also map and implement an intermediate state work flow that improved upon some of the gaps noted while awaiting additional resources necessary to achieve the true target state workflow.

4. **Start with the right location and time of day**: Pick one ED (either adult or pediatrics) and one tour or shift to pilot improvement work.

5. **Whenever possible, the patient should leave with their appointment in hand.**

6. **Consider utilizing guidelines for timing of follow up appointments (tiered urgency)**: Only patients for whom a primary care appointment is clinically necessary should be scheduled for one. Guidance is provided on specific diagnoses requiring follow-up within a maximum of 14 days, included in the detailed best practices within this document.

7. **Get to know your community PCPs to understand the best way to collaborate**
8. **Proactively reach out to patients known to have a high “no-show rate.”** Work closely with ambulatory care clinics to contact patients by phone in advance of primary care appointments to improve the hand-off, with the goal of increased actual attendance.

9. **Hold weekly team meetings for ED schedulers and workgroup members to share and track progress, successes, and challenges**

10. **Success will require collaboration across multiple groups of stakeholders:** Ambulatory care leadership and Information technical are critical to success. The ED workgroup should have diverse representation as well.

11. **If there is currently no method to track something you think is necessary, create it.** If you think something could be measured relatively easily, engage in the necessary conversations with your team to explore a simple method to capture that data.

12. **Educating Users on Changes Made is as Important as Making them.** Any strategy for improvement is only successful if users adopt it, so think carefully about ongoing staff education and dissemination of new practices to promote sustainability.
APPENDIX: PDSA CYCLE

Plan, Do, Study, Act (PDSA) Cycles

The Plan-Do-Study-Act (PDSA) cycle is part of the Institute for Healthcare Improvement Model for Improvement, a simple yet powerful tool for accelerating quality improvement. Once a team has set an aim, established its membership, and developed measures to determine whether a change leads to an improvement, the next step is to test a change in the real work setting. The PDSA cycle is shorthand for testing a change—by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method, used for action-oriented learning.

The steps in the PDSA cycle are:

Step 1: Plan—Plan the test or observation, including a plan for collecting data
Step 2: Do—try out the test on a small scale
Step 3: Study—Set aside time to analyze the data and study the results
Step 4: Act—Refine the change, based on what was learned from the test

For more information:
http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

STEP 1: PLAN

Plan the test or observation, including a plan for collecting data.

- State the objective of the test.
- Make predictions about what will happen and why.
- Develop a plan to test the change. (Who? What? When? Where? What data need to be collected?)

STEP 2: DO

- Try out the test on a small scale.
- Carry out the test.
- Document problems and unexpected observations.

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- Begin analysis of the data.

**STEP 3: STUDY**

Set aside time to analyze the data and study the results.
- Complete the analysis of the data.
- Compare the data to your predictions.
- Summarize and reflect on what was learned.

**STEP 4: ACT**

Refine the change, based on what was learned from the test.
- Determine what modifications should be made.
- Prepare a plan for the next test.

**AIM**

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<tr>
<th>PDSA Cycle # 1</th>
<th>Person(s) Responsible</th>
<th>When to complete</th>
<th>Where to complete</th>
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<tbody>
<tr>
<td>Describe your test of change:</td>
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**PLAN**

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<th>List the tasks needed to set up this test of change</th>
<th>Person(s) Responsible</th>
<th>When to complete</th>
<th>Where to complete</th>
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<th>Predict what will happen when the test is carried out</th>
<th>Indicator to measure if prediction succeeds</th>
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</table>
**DO**

Describe what actually happened when you ran the test.

**STUDY**

Describe the measured results and how they compared to the predictions.

**ACT**

Describe what modifications to the plan will be made for the next cycle from what you learned.