Ready, Set, CALL: Improving Follow-Up Appointments Post Hospital Discharge

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Objectives

• Discuss how to create a workflow to increase follow-up visits post hospital discharge for primary and specialty clinics.
HaysMed

- Western Kansas
- 206 Beds
- 24 CAH (Regional Referral Center)
- ACS Verified Level 3 Trauma Center
- DNV/ISO Accredited
  - Primary Stroke Center
  - Hip & Knee Replacement Certified
  - MIR Certified
  - Society of Cardiovascular Patient Care Accredited Chest Pain Center/PCI

### 2018 Statistics

- Admissions: 5,352
- ED Visits: 11,567
- Associates: 1,221
- Physicians: 69; 44 Consulting
- Specialties: 30
Background

• In a study conducted by Jackson et al., (2015) nearly 20% of patients with multiple comorbidities had a reduction in readmissions if seen within 14 days.
  – Per Lee et al., (2017) adults discharged to home after hospitalization for heart failure, outpatient follow-up within 7 days was associated with lower chance of readmissions.

• However, it was found at one large hospital more than a third of recommendations at discharge was not followed, along with decreased compliance if not scheduled in a timely manner (Moor. C, McGinn. T, Halm. E, 2010).
Unplanned Readmissions

• 35 million hospital discharges annually in the United States

• 3.3 million readmissions across all payers

• Cost of unplanned readmissions
  – AHRQ- $41.3 billion for total hospital cost 2011
  – Medicare beneficiaries most high at $26 billion annually

• CMS penalized over 2,500 hospitals more than $564 million in 2017 for excessive 30-day readmissions

(Alper, E., O’Malley, T., Greenwald, J., 2019)
Discharge Process

Current State: What is happening now?

• First looked at readmissions- why is this happening?

• Reviewing and creating a current state map of the discharge process.

• Observations- “going to the gemba”
  – Ambulatory Surgery
  – Acute
  – CPCU
  – OB
  – Bone/Joint/Spine
Lean Methodology

- The current process of patient discharge was reviewed
Follow-up Appointments

1. **Dismissal Order**
   - **Follow-up Order Placed?**
     - Yes → **Does it state when to see provider**
     - No → **Search for Free Text Order. Found?**
       - Yes → **Call provider for clarification, OR, PCP within 7-10 days**
       - No → **Call provider if patient needs follow-up**

2. **Does it state when to see provider**
   - Yes → **Is the clinic open to phone calls?**
     - Yes → **Set up appointment per patient request**
     - No → **Discuss with patient to schedule their own appointment**
   - No → **Making the patient do the work.**

3. **Document in Discharge Summary**
Root Cause Analysis

- 51% of the time appointments were not being made for patients on the weekends
Opportunities Identified

• Define staff roles

• Identify process for setting up appointments after hours/weekends

• Planned surgeries set-up follow-up appointment at surgery scheduling time
Collaboration

• Nursing
  – Discussed with all dismissing floors

• Discharge Planners

• Clinic Staff
  – Managers/Supervisors
  – Front office staff

• Clinical Care Coordinators

Iceberg of Problems
 VP- 4%
 Directors- 9%
 Supervisors- 74%
 Frontline Staff 100%
**Action Plan:** Pilot Cardiology and Medical Specialty

- Afterhours and Weekends fax sheets
- Follow-up calls from clinics to the patient next business day

*Goal electronic, at this time our system inpatient does not speak to outpatient...tried next best thing!*
Priority #1

• Educate staff on the importance of scheduling follow-up appointments

Priority #2

• Create a workflow to identify who was all involved in the new process along with scripting.
<table>
<thead>
<tr>
<th>Patient Label</th>
<th>Date of Dismissal</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Procedure</td>
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Fax to the clinic at 785-261-7424
Add in notes examples:

– “can’t hear very well”
– “ask for the son for scheduling”
– “leave a message so he can read it with his phone and he will call back”
PILOT: Hospital Workflow for CARDIOLOGY AND MED SPECIALTY

RN to ask patient preferred days and time for follow up appointment

Open Clinic Hours Outside of 1200-1300
  → RN to call clinic to set up appointment
  → Document on dismissal summary

Weekday Lunch Hours 1200-1300
  → RN to call backline number provided by clinic
  → Document on dismissal summary

After Hours and Weekends
  → RN to place patient sticker on fax sheet with additional information for the clinic to call
  → Fax to clinic the next working AM
  → Keep completed fax sheet. Place in designated folder

**If patient requests to make their own appointment**
1) RN to document in dismissal summary “patient request to make their own appointment.”
2) RN to place patient sticker on fax sheet for either cardiology or medical specialty and fax in am for clinic to make courtesy call
Phase 1

• Two clinics:
  – cardiology and internal medicine

• After 3 months, the pilot was deemed successful

• Positive feedback from both patients and staff
# Lessons Learned

- Staff feedback/requests
- Documentation

<table>
<thead>
<tr>
<th>Doctor's Appointment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Post Discharge orders scheduled</td>
<td></td>
</tr>
<tr>
<td>If Unable to Schedule Post Discharge appt./orders, were contact phone #/s given to pt/family. Report Called to</td>
<td></td>
</tr>
</tbody>
</table>

- **Scheduled appointment**
- **Fax request to clinic**
- **Patient/Family will schedule**
- **Other:**
  - **Yes**  **No**  **Comment:**
  
  i.e., Lab, Diagnostic tests, PT/OT/ST, Cardiac/Pulmonary Rehab, Home Health, Special Nursing services.
  - **Yes**  **No**  **Comment:**
Discharge Checklist

Add Instructions:
- New/Admission Diagnosis
- New or Changed Medications
- Foley Drains: PICC line: Oxygen
- New Diets
- Labs: blood sugars, blood pressure, drain output record

Surgical Patients
- Lifting restrictions
- Dressing Removal or Changes.

Follow-up Appointments:
- All patients must have a follow up with a PCP in 5-7 days.
- Check with all consults to see if patient needs a follow up.
- Check for office appointment orders.
- AFTER HOURS: Use the fax sheet located at the nurses station to provide the office with information on the patient and when a follow up is needed.

Home Health Orders
- Contact case manager to arrange home health
- Call report to the home health agency

Transportation Options:
- B&I/Convenience Cab
- Shuttle Services
- Access
- Lastly Security

Verify patient has received flu or pneumonia vaccine if necessary

Education:
- Coumadin Education-Pharmacy completes
- New Diabetes Education-Patient educator completes
- Ostomy Education (Script for ostomy supplies) - Patient educator completes
- Diet: Dietician completes

Remember before a patient leaves:
- Check lockboxes
- Check room for patient belongings

Medications:
- Check with patient to verify they are able to afford the cost of their medications. If needed, call the pharmacy and get a price check. Contact case manager if unable to afford meds.
- Send insulin pens/inhalers to pharmacy to be labeled for home use.
- When sending patients on pain meds use the generic PAIN MEDICATION: HMC Instructions not the specific medication.

Ambulatory Orders:
- If imaging is ordered, fax order to COPS (6564). Call COPS at 785-623-6565 to schedule. If it is the weekend, please give the patient COPS number to call if questions.
  - If the patient wants orders done at another hospital please fax the order to that hospital and call to arrange.
- To setup nursing care (wound care/IV antibiotics) contact the case manager.
- Lab Orders: ensure these orders are printed; instruct patient they must take the order with them to the lab of their choice.
Mr Apple, CPCU  
DOB 1/19/1954

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Date of Dismissal</th>
<th>Doctor</th>
<th>Follow-up Time Frame</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertensive Crisis</td>
<td>3/2/19</td>
<td>Dr. Smith</td>
<td>5-7 days</td>
<td>913-588-0000</td>
</tr>
</tbody>
</table>
Phase 2

• Adding in all clinics (11)
  – Cardiology, internal medicine, family medicine, orthopedics, surgical, oncology, pediatrics, obstetrics-gynecology, pulmonology, urology and nephrology.

• Currently on month 2 of Phase 2
  – Positive results and feedback
Monthly Chart Audits

• Each floor
  – Audited over 600 charts

• Track compliance
  – Report back to directors
  – Send emails of thanks
  – Post results on floors
    • Friendly competition
Outcomes

- Increased compliance
  - to date >153 faxes sent

- Proactive in scheduling appointments if knowing discharging after hours
  - Nursing and providers

- Patients voiced appreciation for the phone calls with one stating “I am grateful for this”, and another stating “thank you for calling; I forgot I needed to follow-up”.

![Follow-up Appointments Made](image)
Poster Presentation: “Ready, Set, FOLLOW-UP: Utilizing Community Care Coordination to Decrease Readmission and ED Visits”

Graph 1: All Payor RA Rate

Graph 2: Medicare 30 Day RA Rate
Barriers

• New staff/ travelers

• Providers not clear in discharge instructions

• No primary care doctor

• Outside primary care doctor/ traveling on I70

• Follow-up visit already scheduled but for 2-3 weeks out rather than a week
Next Steps

• Continue with Phase 2 pilot

• Internal goal- ≥ 90% of Medicare patients have a follow-up appointment at discharge or called the next business day
  – Currently meeting

• Phase 3: Partner with community providers and surrounding counties to utilize faxes after hours for scheduling patients.

• Create project with ER
Lessons Learned

• PDCA
  – Review, review, review, the process
  – Audit frequently – both hospital and clinic side
  – FOLLOW-UP

• Frontline staff have GREAT ideas!!

• Celebrate the small wins
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References


