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

Kelsey Accurso, MS, APRN, AGCNS-BC

Objectives

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

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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?

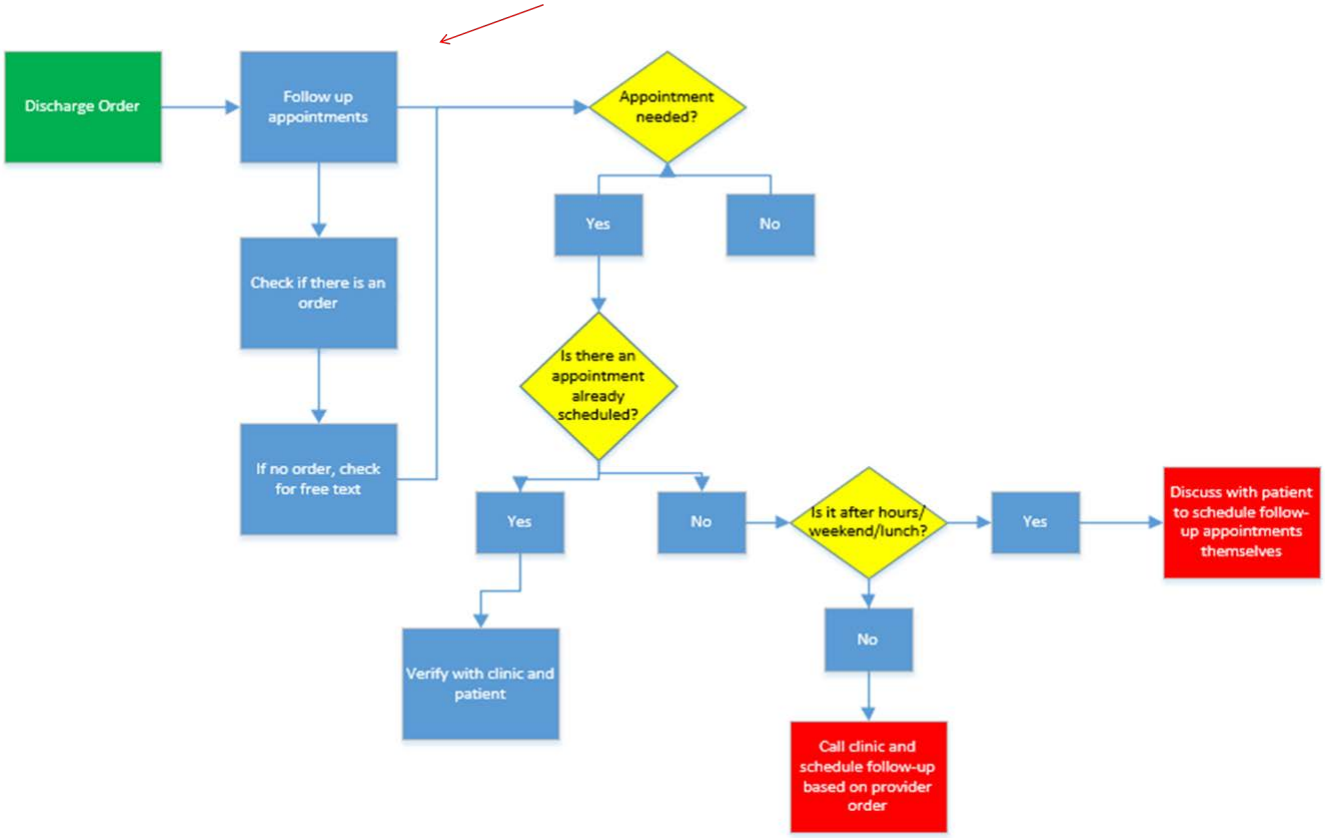
- First looked at readmissions- why is this happening?

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

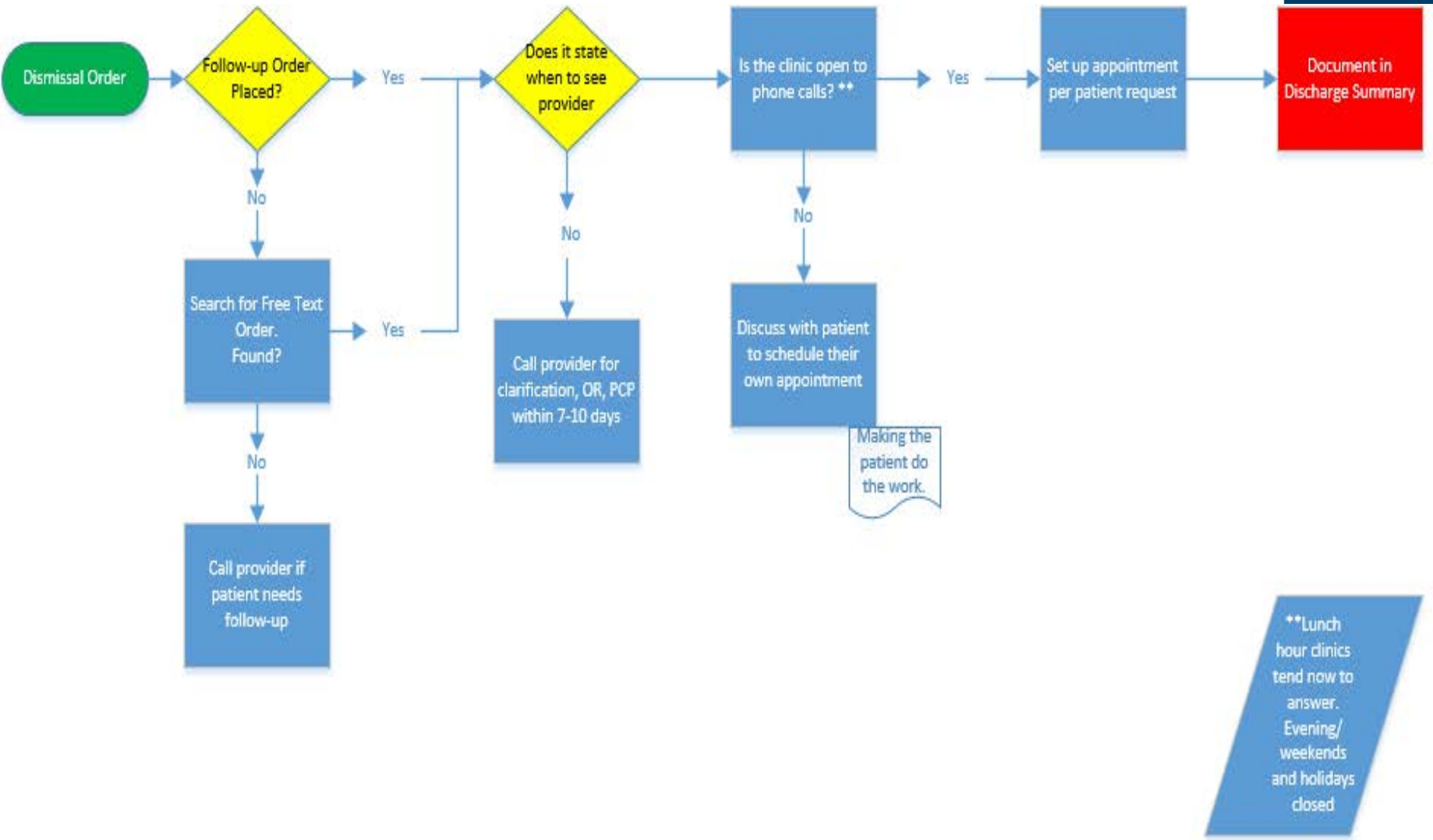
- Observations- “going to the gemba”
  - Ambulatory Surgery
  - Acute
  - CPCU
  - OB
  - Bone/Joint/Spine

Lean Methodology

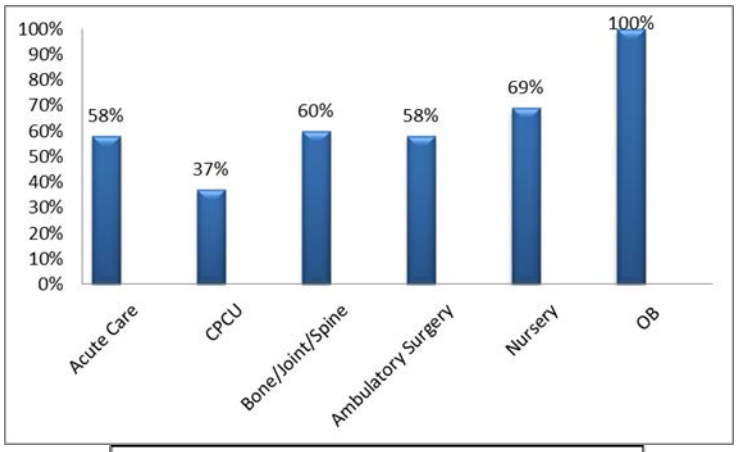
- The current process of patient discharge was reviewed



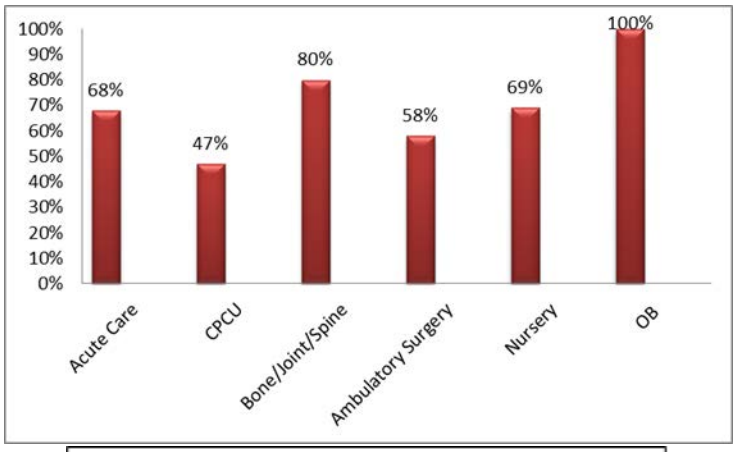
Follow-up Appointments



Root Cause Analysis



Scheduled Follow-up Appointments*



Partial Scheduled Follow-up Appointments**

- 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

Eliminate Extra Work for the Patient!

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.

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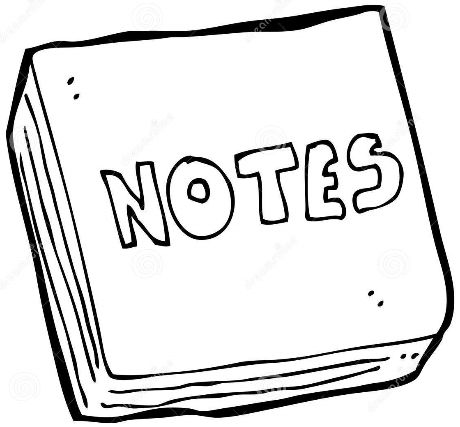
DeBakey Heart Institute
After Hours/Weekend Discharge Patient List

Fax to the clinic at 785-261-7424

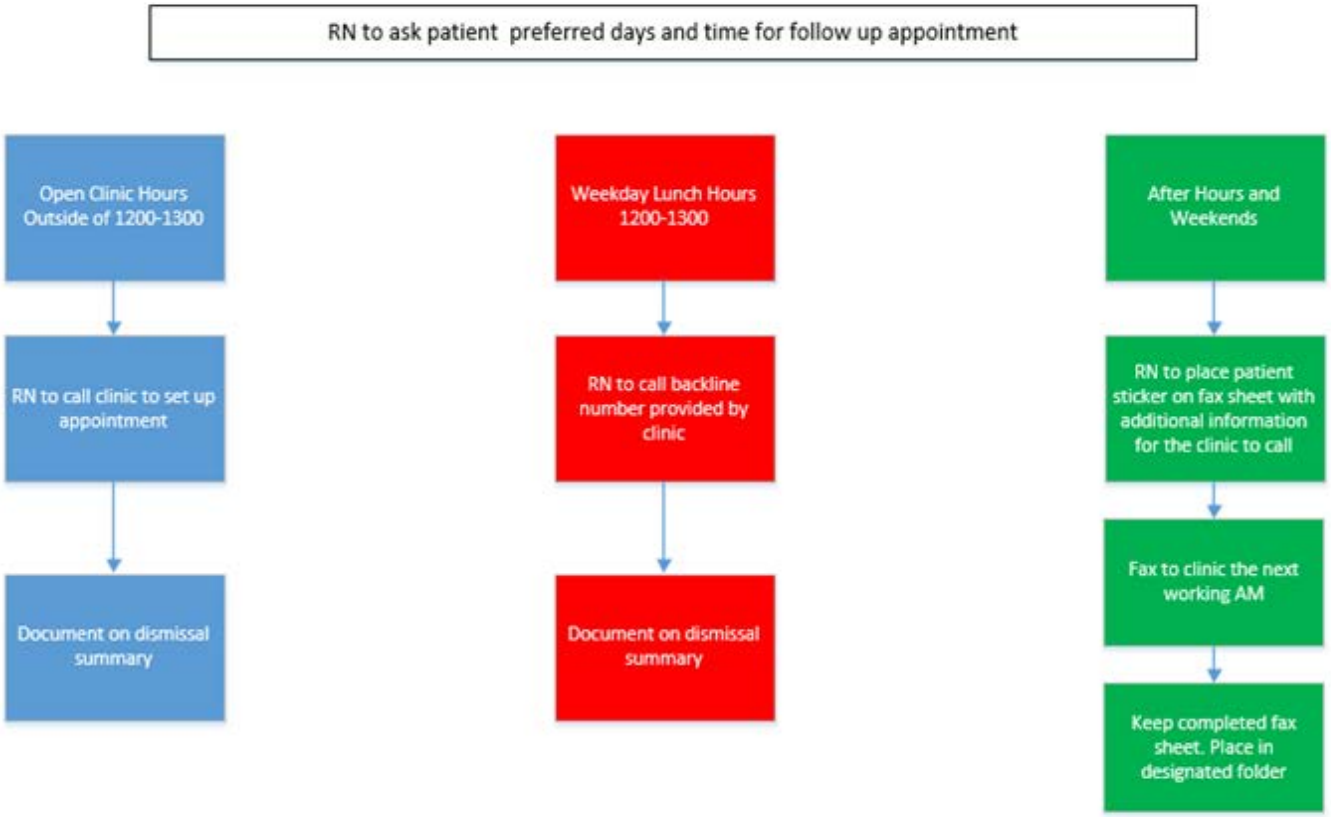
Patient Label	**Date of Dismissal**	
	Doctor	
	Follow-up Time Frame	
Procedure:	**Phone #**	
Patient Label	**Date of Dismissal**	
	Doctor	
	Follow-up Time Frame	
Procedure:	**Phone #**	
Patient Label	**Date of Dismissal**	
	Doctor	
	Follow-up Time Frame	

Add in notes examples:

- “cant 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”



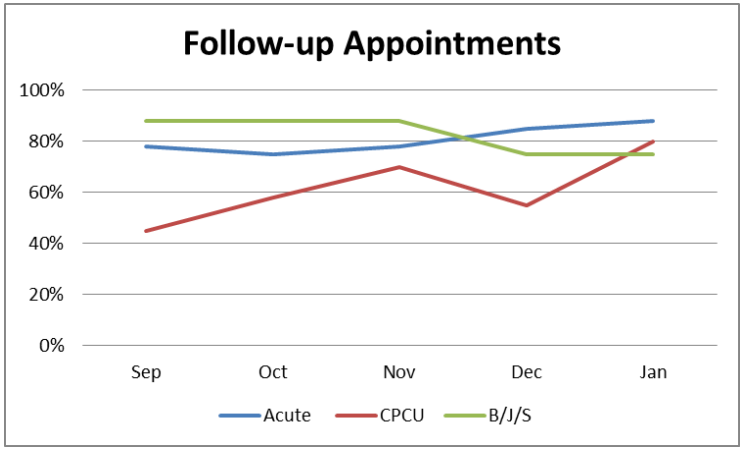
PILOT: Hospital Workflow for CARDIOLOGY AND MED SPECIALTY



****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

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Discharge Checklist

Add Instructions:

- ✓ New/Admission Diagnosis
- ✓ New or Changed Medications
- ✓ Foley-Drains-PICC line-Oxygen
- ✓ New Diets
- ✓ Logs for: blood sugars, blood pressure, drain output record

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 sheets located at the nurses station to provide the office with information on the patient and when a follow up is needed

Surgical Patients

- ✓ Lifting restrictions
- ✓ Dressing Removal or Changes.

Home Health Orders

- ✓ Contact case manager to arrange home health
- ✓ Call report to the home health agency

Transportation Options:

- ✓ B&B/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 set up 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.

Scheduled Date

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DeBakey Heart Institute
After Hours/Weekend Discharge Patient List

Fax to the clinic at 785-261-7424

Patient Label Mr Apple, CPCU DOB 1/19/1954	Date of Dismissal	3/2/19
	Doctor	Dr. Smith
	Follow-up Time Frame	5-7 days
Procedure: Hypertensive Crisis	Phone #	913-588-0000
Patient Label	Date of Dismissal	
	Doctor	
	Follow-up Time Frame	
Procedure:	Phone #	
Patient Label	Date of Dismissal	
	Doctor	
	Follow-up Time Frame	

3/5/19
Curtis

Phase 2

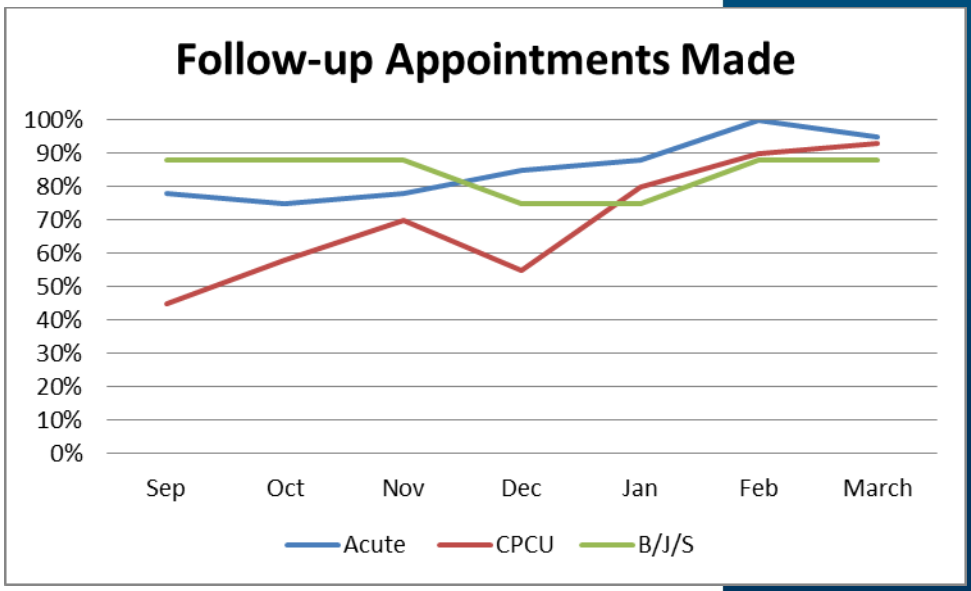
- Adding in all clinics (11)
  - Cardiology, internal medicine, family medicine, orthopedics, surgical, oncology, pediatrics, obstetrics-gynecology, pulmonology, urology and nephrology.

- Currently on month 2 of Phase 2
  - Positive results and feedback

Monthly Chart Audits

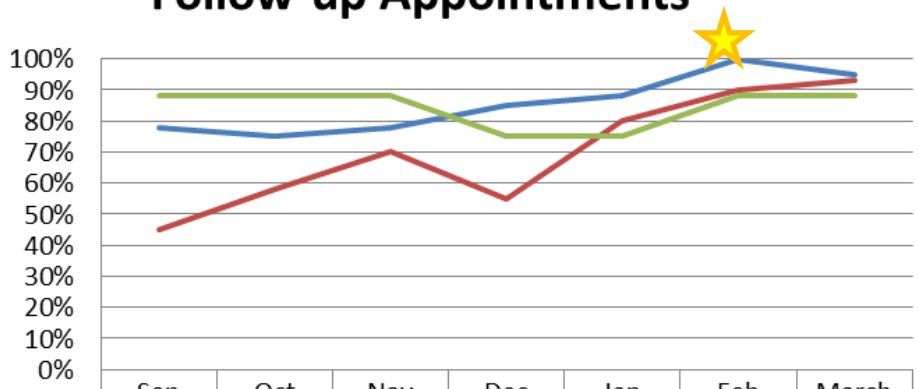
- Each floor
  - Audited over 600 charts
- Track compliance
  - Report back to directors
  - Send emails of thanks
  - Post results on floors
    - Friendly competition

Outcomes

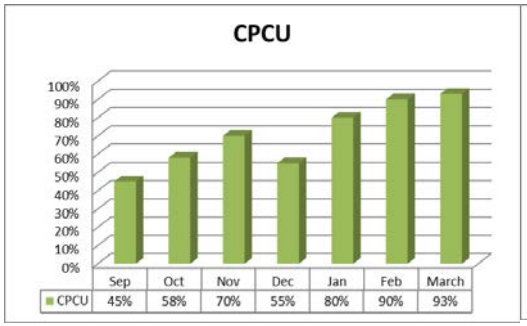


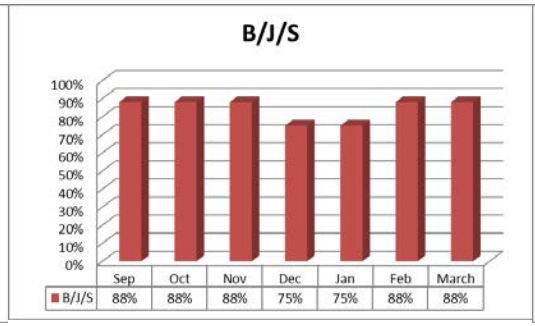
- Increased compliance
  - to date >153 faxes sent
- Proactive in scheduling appointments if knowing discharging after hours
  - Nursing and providers
- Patients voiced appreciation for the phone calls with one stating “I am grateful for this”, and another stating “thank you for calling; I forgot I needed to follow-up”.

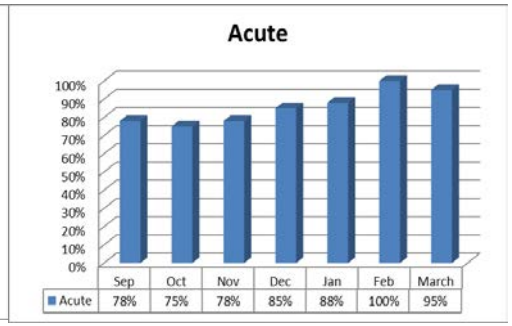
Follow-up Appointments



	Sep	Oct	Nov	Dec	Jan	Feb	March
Acute	78%	75%	78%	85%	88%	100%	95%
CPCU	45%	58%	70%	55%	80%	90%	93%
B/J/S	88%	88%	88%	75%	75%	88%	88%

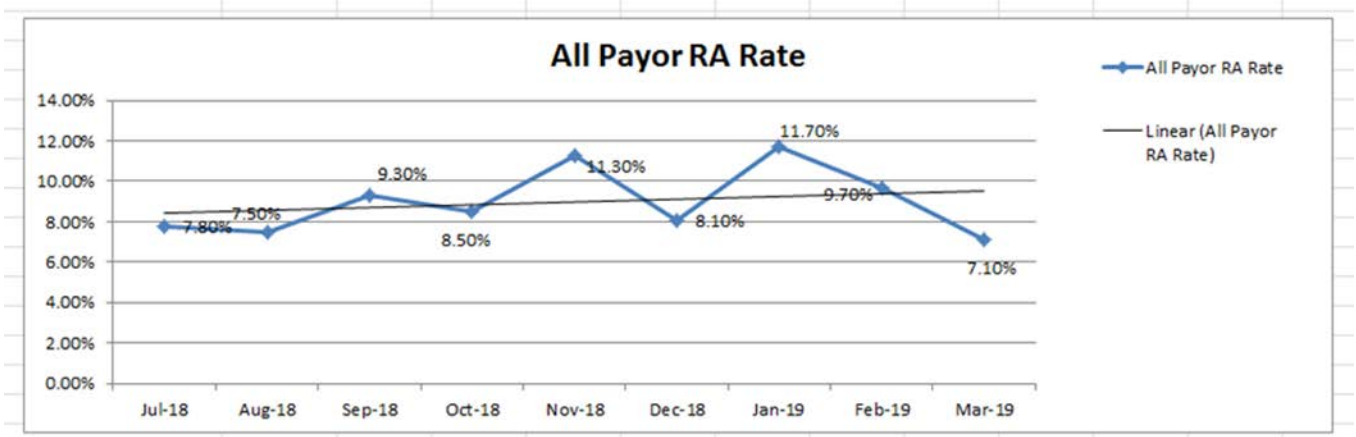


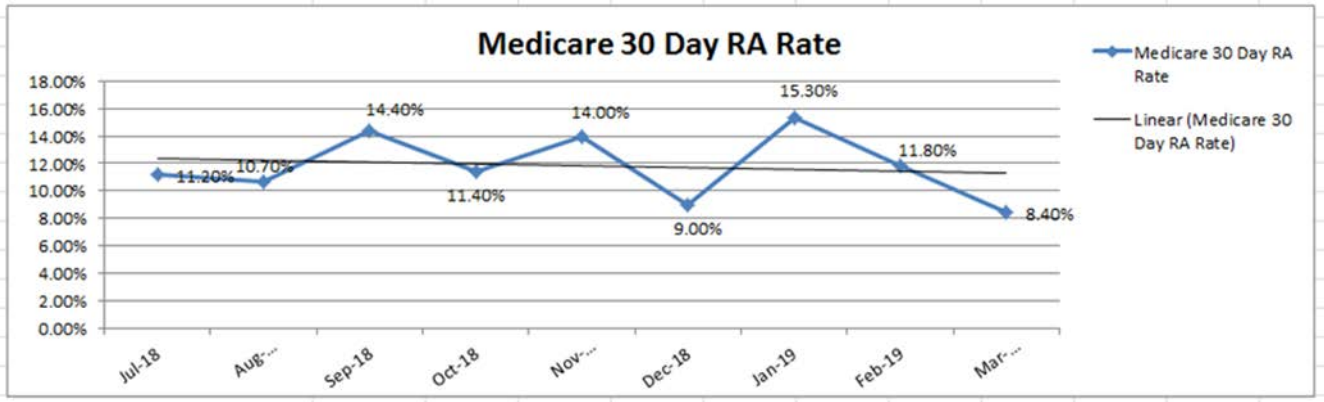




Readmissions Improvement Projects

Poster Presentation: "Ready, Set, FOLLOW-UP: Utilizing Community Care Coordination to Decrease Readmission and ED Visits"





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

Kelsey.Accurso@haysmed.com

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