Introduction

Post-hospital discharge follow-up appointments with primary care provider are associated with lower 30-day readmission rates.

Follow-up appointments are critical opportunities to review discharge information, reconcile medications, and coordinate interdisciplinary care.

Of all patients discharged from the Jefferson Family Medicine Associates (JFMA) hospital service

- Only 66.6% had a follow-up appointment scheduled
- Only 53.5% completed a follow-up appointment within 14 days

Currently, JFMA patients are verbally instructed to schedule a follow-up appointment with their PCP on the day of discharge.

Meeting with the following stakeholders:

- Liz Lewallen, population health specialist
- JFMA residents and faculty
- Sylvia Cruz, case manager

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Aim

Increase percentage of JFMA patients with follow-up appointment scheduled after discharge to 100% by March 2018

Increase percentage of JFMA patients who show up to their follow-up appointments after discharge to 80% by March 2018

Methods

Meeting with the following stakeholders:

- JFMA residents and faculty
- Sylvia Cruz, case manager
- Liz Lewallen, population health specialist
- Brainstorming and prioritization of changes with resident team and advisor

PDAS #1: October 16, 2017 - February 11, 2018

- JFMA senior residents updated the patient’s personal and emergency contact information in the electronic medical record (EMR)
- Allowed case managers to contact patients more effectively and efficiently, to facilitate transition of care

PDAS #2: February 12, 2018 - April 15, 2018

- JFMA hospital team provided a self-directed appointment scheduling form, for the patient or caregiver to schedule their own appointments prior to discharge

- Created a standardized Epic report to determine hospital discharge data
- Data collected: patient name, MRN, DOB, date of admission, date of discharge, discharge disposition, PCP insurance provider

Results

- In PDAS #1, percentage of patients who had an appointment scheduled decreased to 29.1% from a baseline of 69.4% and percentage of patients who showed to their appointment decreased to 46.6% from baseline of 53.5%
- In PDAS #2, percentage of patients who had an appointment scheduled increased to 72.7% and percentage of patients who showed to their appointment increased to 55.7%
- During PDAS #2, a total of 44 patients received the intervention form
- Patients in PDAS #2 who received the intervention form were more likely to have a follow-up appointment scheduled and were more likely to show to those appointments

Discussion

- The primary outcome decreased after change #1, possibly reflecting a more accurate baseline
  - Many residents reported not updating contact information in the EMR (poor fidelity of intervention)
  - On chart review, the majority of phone numbers were correct
- For change #2, there was an increase in the primary outcome
  - The change was not robust enough to achieve our aim, but this may be due to provider non-compliance (fidelity of the intervention)
  - As a balancing measure, some residents noted difficulty in handing out the intervention form due to competing demands related to patient care
- Patients who did receive our intervention form in change #2 were more likely to schedule and show to follow up appointments, suggesting this is a meaningful target for ongoing intervention. The use of existing resources may help facilitate meaningful change.

Future Directions

- Utilize alternative staffing to achieve sustainability
  - As a result of our project, there is now a new transition of care medical assistant
  - Requires further stakeholder involvement and brainstorming
- Determine patient satisfaction with newly implemented practices
- Consider implementing our intervention into a formal discharge checklist
- Consider expanding our intervention to other hospital services, not just JFMA

References: