Off to the Doctor we go

Heigh Ho! Heigh Ho!

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Goal/Quality Improvement Idea in Case Management:

To increase the number of patients who are scheduled for clinically appropriate follow up appointments within 7-14 days of discharge to 100% in order to help improve readmission rates

Background & Purpose

- South Pointe's readmission rates in December 2015 were 19%, and 17.2% in 2016, the highest in the enterprise.
- Follow up appointments were attempted by Case Management in conjunction with HUC's (Health Unit Coordinators). Appointments were made inconsistently due to multiple reasons.
- Patient's often did not follow through with scheduling their own appointments as instructed on the AVS (After Visit Summary) form, or they were not aware that they needed to call and schedule follow-up appointments.
- Gaps and inconsistency in scheduled follow up appointments may be one factor that contributes to high readmission rates.
- SPH Case Management and Case Management Resource Center collaborated in scheduling PCP and Specialty appointments 7-14 days after hospital discharge.

Review of Literature

- Unplanned hospital readmissions within 30 days of discharge is an indicator of poor quality and is responsible for increased healthcare spending *(Field, Ogarek, Garber, Reed & Gurwitz, 2014).* For excessive 30-day rehospitalizations heavy fines and penalties have been levied by The Centers for Medicare & Medicaid Services (CMS) under the Affordable Health Care Act. It has been estimated that rehospitalizations have resulted in a total of $15 billion in Medicare spending *(Watkins, Hall, Kring, 2012*).
- Research shows that patients are at high risk when transitioning between inpatient and outpatient settings resulting in more hospitals implementing hospital-initiated care transitions focusing on preventing adverse events, emergency room visits and hospital readmissions post hospital discharge *(Rennke, Nguyen, Shoeb, Magan, Wachter, Ranji, 2013).*
- Research identifies one approach in preventing rehospitalizations is early follow-up, usually defined as an office visit with a primary care physician within 7 days of discharge. Some studies supports a positive impact on readmissions for an office visit with a primary care physician within 7 days, other studies indicate a lack of benefit. (*Ryan, Kang, Dolacky, Ingrassia, Ganeshan, 2013)*

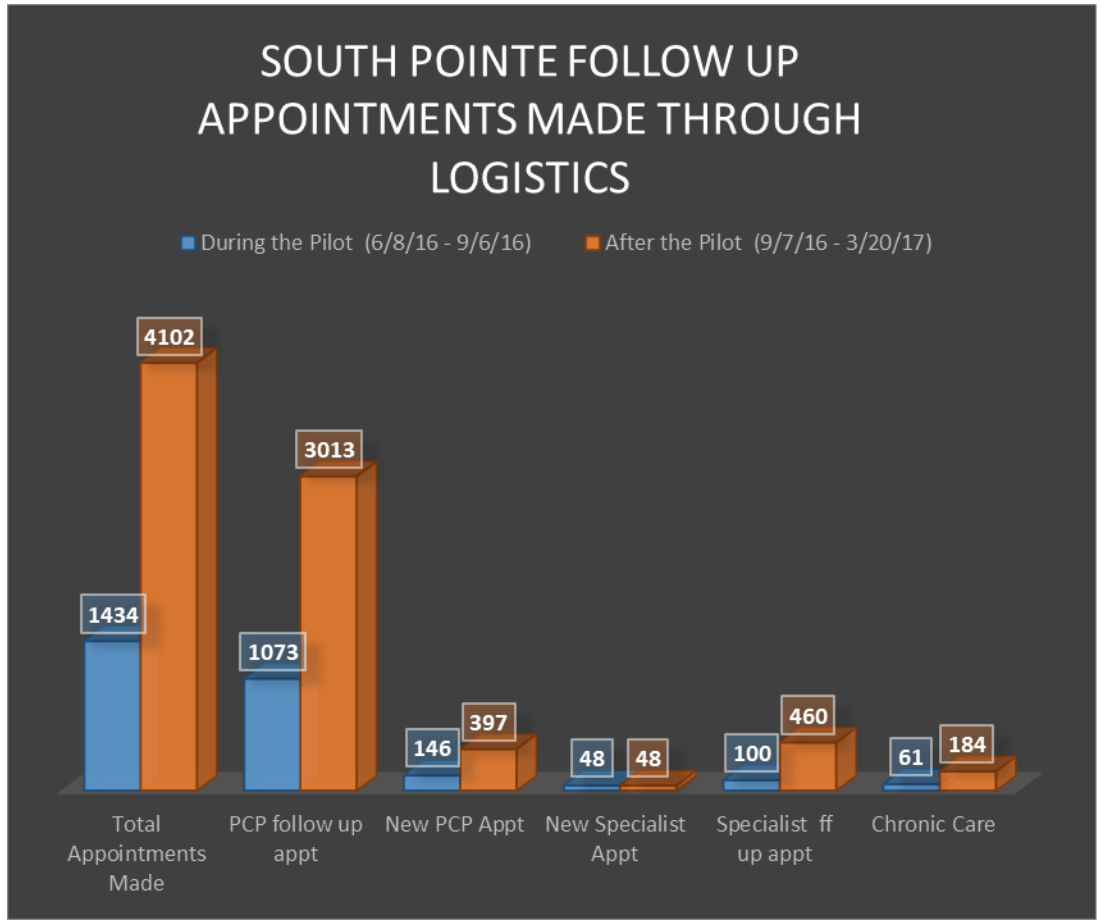
Methods

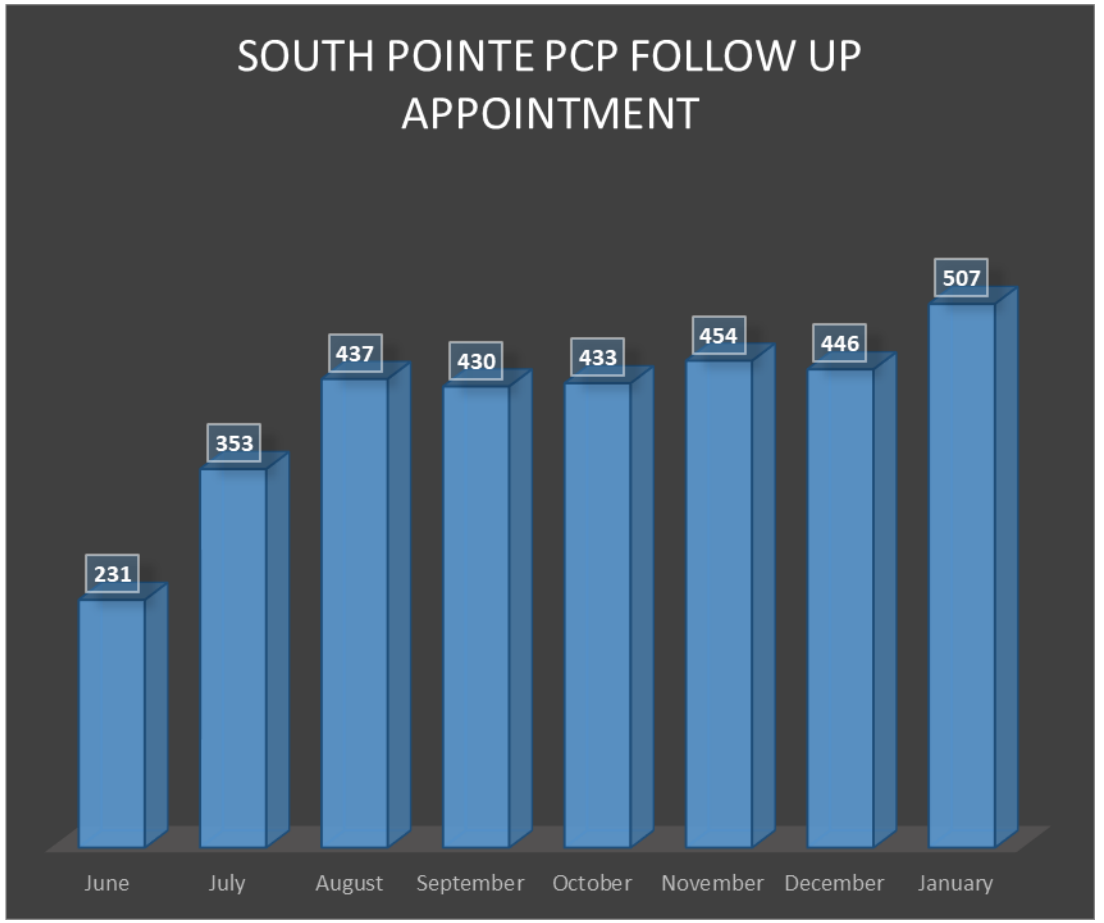
- Case managers (CM) notify the Case Management Resource Center (CMRC) of all patients who are to be discharge to home or assisted living
- The CM first determines if the patient has a primary care provider, if not they will be referred to the Internal Medicine Clinic for follow-up
- The CM also determines if the patient needs a specialty clinic visit
- All information is forwarded to the CMRC resource through ECIN.
- CMRC contacts providers to make the appointments, which is entered in EPIC and ECIN, and flows to the After Visit Summary (AVS)
- The RN educates the patient and family about the appointment prior to discharge

Outcome Data

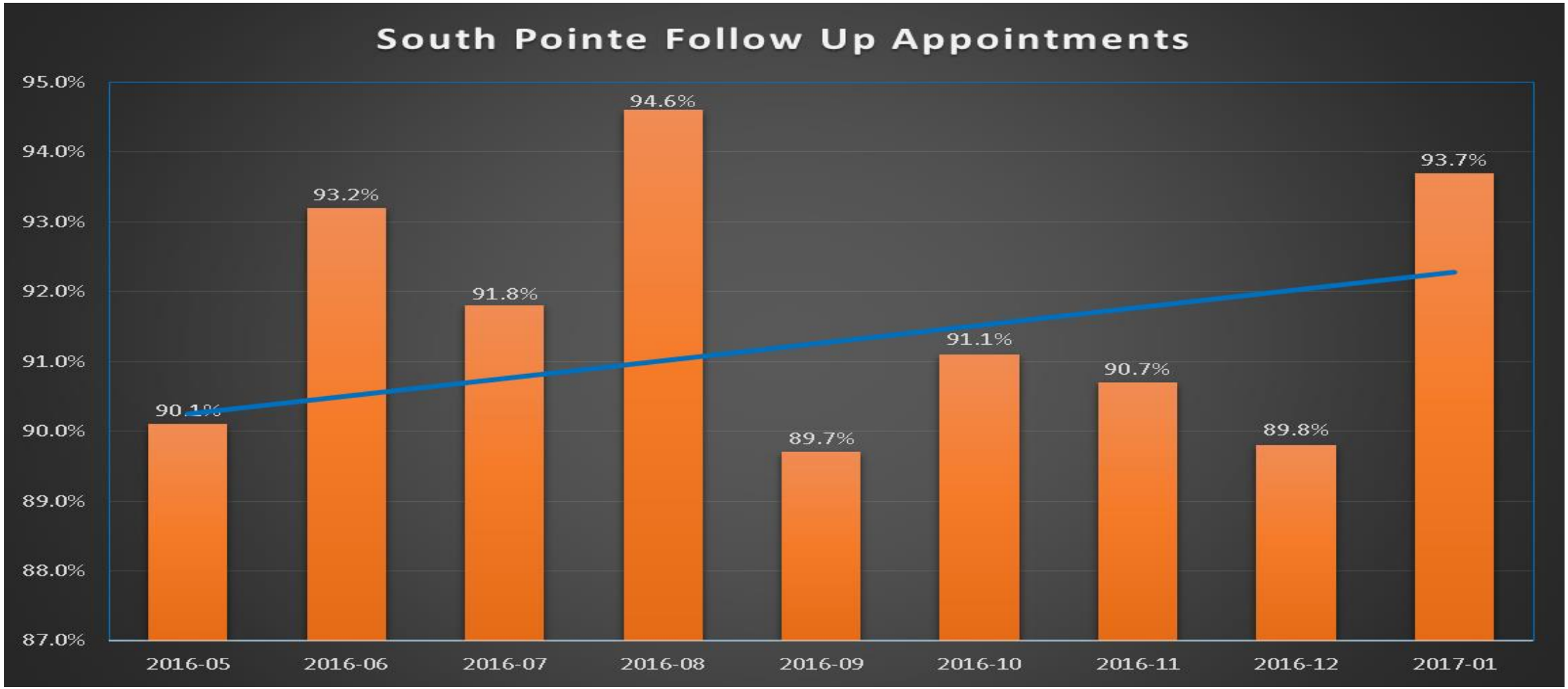
- Pre-Intervention, our goal was to have 100% of patients scheduled with a PCP, or in the Specialty Care Clinic, with every patient having a scheduled appointment within 7-14 days post hospital discharge.
- At the conclusion of the South Pointe pilot we had 1,434 total confirmed post hospital appointments (93.7%), with PCP's, Specialists, and Chronic Care Clinics.
- After the pilot program South Pointe continued post hospital appointments with an increase of scheduled appointments to 5536.
- Data for months December 2015 through January 2017 show overall decrease in readmissions to South Pointe Hospital.

Follow-Up Appointments

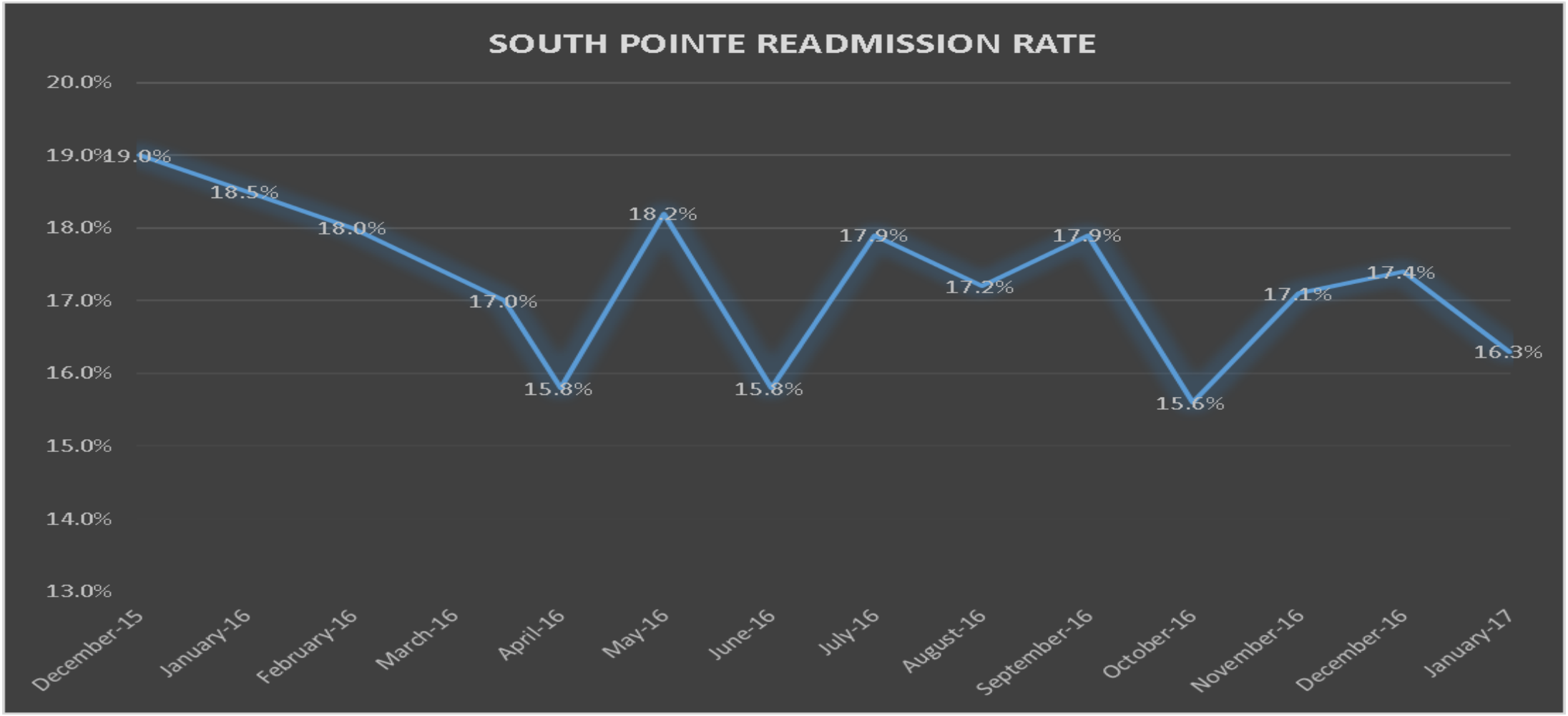




Appointment Trends



Readmission Rate Trend



Conclusion

- Our South Pointe Case Management team in conjunction with Case Management Resource Center was able to improve scheduling of 7-14 day follow up appointments for patients post hospitalization with their community partners. This process has implications for assisting in reducing all-cause 30-day readmissions.
- The readmission rates for December 2015 to January 2017 suggest that scheduling the 7-14 day follow up visit, as one of the core 4 components (post discharge follow-up appointments, discharge summary within 48 hours, medication reconciliation on admission, medication reconciliation at discharge), can impact in decreasing readmissions.
- As a result of this success, Cleveland Clinic decided to roll out this initiative to the Enterprise. As of March 2017 initiative has been rolled out and includes Marymount, Euclid, Lutheran and portions of Main Campus.

References

- Field S., Ogarek J., Garber L., Reed G., Gurwitz H. Association of Early Post-Discharge Follow-up by a Primary Care Physician and 30-Day Rehospitalization Among Older Adults. J Gen Internal Med. 2014: 30(5):565-71.
- Watkins L., Hall C., Kring D. (2012). Hospital Home: A Transitional Program of Frail Older Adults. Professional Case Management. 2013;17(3):117-123.
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- Ryan J., Kang S., Dolacky S., Ingrassia J., Ganeshan R. Change in Readmissions and Follow-up as Part of a Heart Failure Readmission Quality Improvement Initiative. The American Journal of Medicine. 2013;126:989-994.