



Improving Outpatient Follow Up After Hospitalization

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Introduction

- Hospital readmission is costly in terms of patient well-being, quality of life, and healthcare expenditures.
- AIM statement: To increase post-hospital discharge follow-up by 20% for academic primary care patients admitted to a local tertiary care hospital by June 2020.



Methods

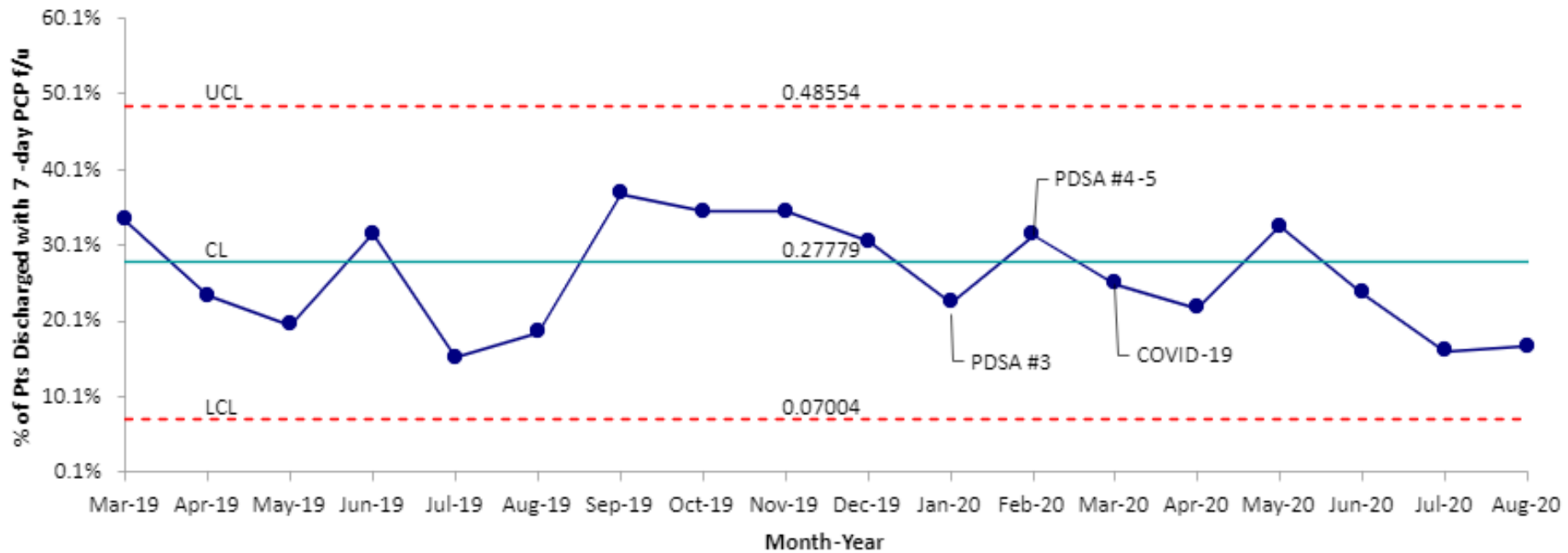
Plan-Do-Study-Act (PDSA)

- PDSA #1: Senior residents called clinic
- PDSA #2: Attempted to give discharge coordinators access to hospital EMR
- PDSA #3: Senior residents were given access to the clinic EMR scheduling program.
- PDSA #4: Home visits



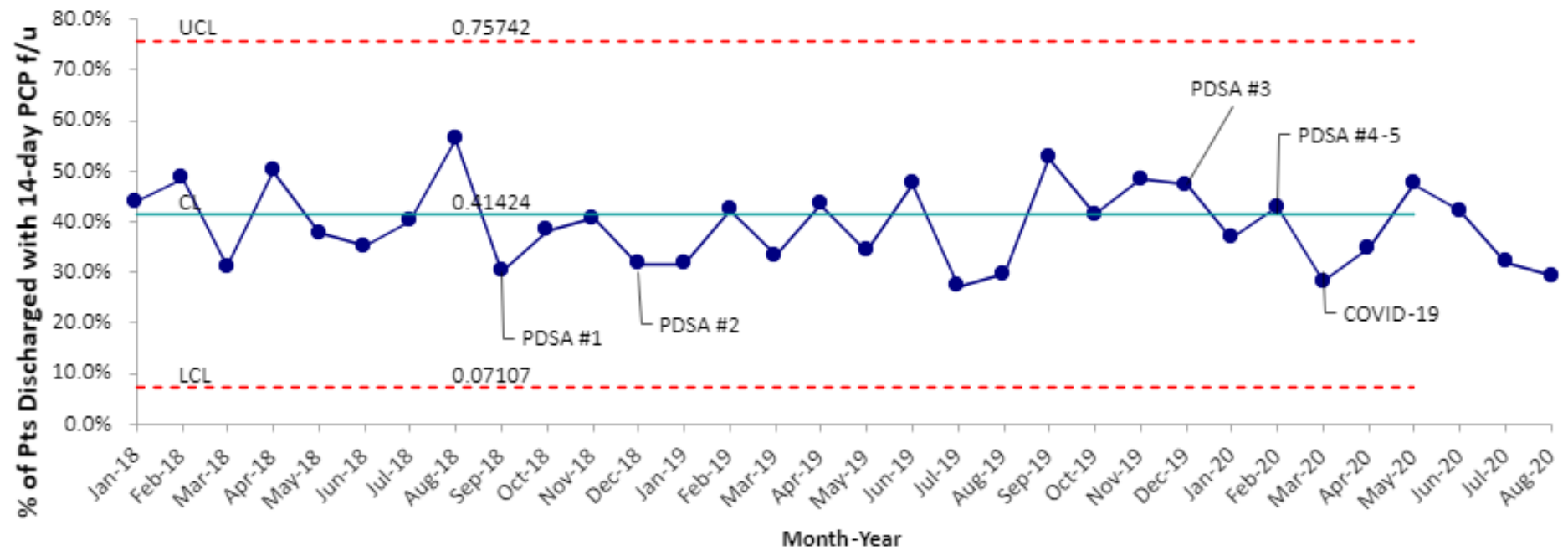
Results

OU Hospital Discharges - 7 Day PCP Follow-up



Results

OU Hospital Discharges - 14 Day PCP Follow-up Rate



Discussion

- The low rate of post-hospital discharge follow-up appointments indicates that many patients are lacking crucial follow-up care.
- Making residents responsible for scheduling appointments (PDSA 1 and 3) and enrolling patients for home visits (PDSA 4) made no difference in the overall rate of successful post-discharge follow-up visits
- New approaches to significant post-discharge follow-up barriers must be considered to increase the percentage of successful follow-up appointments



Next Steps

Future PDSA cycles to consider include:

- Reimplementing home visits
- Surveying similar academic programs regarding their success with post-discharge patient follow-up visits
- Designating other team members to make follow-up visits for patients
- Reaching out to patients early after discharge to confirm their follow-up visits

