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

% of Pts Discharged with 7-day PCP f/u

Month-Year


UCL 0.48554
CL 0.27779
LCL 0.07004

PDSA #4-5
PDSA #3
COVID-19
Results

OU Hospital Discharges - 14 Day PCP Follow-up Rate

% of Pts Discharged with 14-day PCP F/u

- UCL
- LCL

- 0.75742
- 0.41424
- 0.07107

PDSA #1
PDSA #2
PDSA #3
PDSA #4-5
COVID-19

Month-Year

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