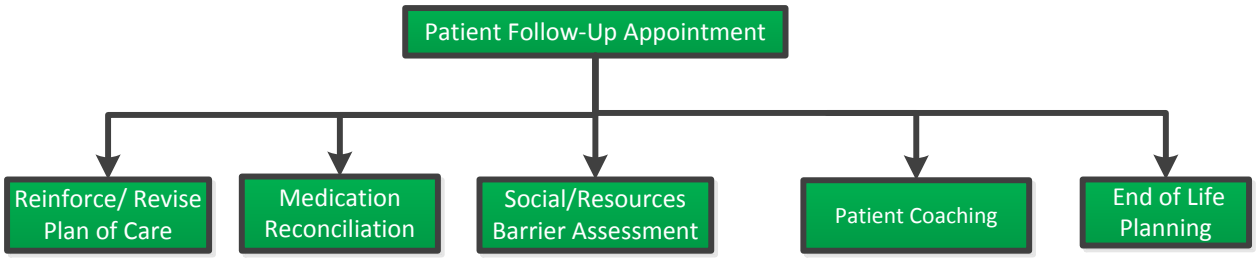
11. Follow-up Appointment - Primary Care Visit



The post-hospital follow-up visit addresses clinical condition(s) that resulted in hospitalization to support and coach the patient and their caregiver regarding the condition. The PCP will perform medication reconciliation, discuss warning signs, when to call, diet, daily activities, and a list of things to follow and things to avoid. It is also an opportunity to discuss end of life planning, assess social barriers, reinforce and adjust the plan of care as necessary and also to perform medication reconciliation and medication management.

Process

- Allow sufficient appointment time for a thorough examination and to address post-discharge follow-up items.
- Utilize Teach Back and health literacy concepts; engage patients in goal setting and shared decision making.
- Provide opportunities for the patient/caregiver to ask questions. Use open-ended questions to create interactive discussions.
- Set up the appointments in a structured format so that the visit will cover all the important discussions.
- Utilize a checklist to ensure that all needed follow-up conversations and services occur (Tool 11).

In Practice

A hospital in our region includes "*Issues to be discussed at the follow-up appointment*" in their standard discharge summary. This usually includes repeat examinations or investigations, test results to follow up and medication adjustments. Outpatient providers find this particularly helpful as they can plan ahead prior to patient's follow-up appointment.

12. Feedback to Hospital for Improvement

In the interest of continuous learning and improvement, PCPs and other pre- and post-acute care providers are encouraged to provide feedback to the hospitals regarding issues with the transition. This feedback will improve the process for future patients and could be discussed in the community forum

(see Section 13 Community Forum). A sample feedback form is also included in the Tools section (Tool 12).

Process

- Pre- and post-acute care providers, patients and their families should provide feedback to the hospitals using a form such as the sample (Tool 12), at a community forum, using patient and family resource phone number or provider feedback phone number.
- The community comprised of leadership from the hospitals, pre- and post-acute care providers, patients and their families should review the feedback together in their forum and establish process to improve transitions.

In Practice

A clinic in our region tracks and follows up with high and moderate readmission risk patients who did not come for their follow-up appointment. The information gathered from the patient is provided to the hospital staff so the hospital staff is able to identify missed opportunities and improve the process as needed.

13. Community Forum

Community Forum

As hospitals work to standardize their internal processes for improving care transition-related work, they also begin to focus on improving cross-continuum care transition practices. A community forum is a meeting of stakeholders in the continuum of care to focus on ways to enhance care transitions in that community. These may be led by hospitals but are often more effective if the leadership is across the continuum and facilitated by neutral parties. The community forum should include patients, physicians, hospital staff, clinical and operational staff from skilled nursing facilities, home health, mental health, palliative care/hospice programs, home care providers, acute and sub-acute care providers, representatives from community agencies, patient and family representatives and payors. The community forum should meet at least quarterly to identify gaps and propose potential solutions with a goal of improving care transitions. Using the discussions to uncover and understand the challenges and barriers each area is experiencing will create opportunities to review and negotiate how the community as a whole can implement reliable and sustainable system change processes and practices that work for all patients for better population health.

Process

- Review data on the population health status in the community, readmission rates, services provided by the hospitals and clinics in the area and relationships between care settings to analyze gaps.
- Align and collaborate with existing community groups and initiatives to avoid duplication of efforts.
- Identify the key players including engaged and committed leaders who are able to get buy-in from the community.

- Identify the motivating issues and make the urgency clear, concise and visible.
- Develop charters, memorandums of agreement and understanding. Set clear goals and create common value.
- Start with small and specific focused processes. Be mindful of distractions and shifting priorities.
- Monitor the improvement with data and adjust the process improvement implementation as needed. Share learnings through the Washington State Hospital Association Safe Tables.

Colorado Foundation for Medical Care (CFMC)'s Community Care Transitions Toolkit provides additional information, resources and tools needed to start your own community care transitions initiative.

Tools

Tool 1.1: Triage Grid: Follow-up and Interventions Based on Patients' Readmission Risk

Risk	High	Moderate	Low
Categories	• Admitted 2 or more times in the past year • Unable to Teach Back • Low likelihood to follow treatment plan • High likelihood patient readmitted within 30 days	• Admitted once in the past year • Moderate likelihood to follow treatment plan • Moderate likelihood patient readmitted within 30 days	• No other admission in the past year • Able to Teach Back • Low likelihood patient readmitted within 30 days
Appointment Needed w/in	48 hours	5 – 7 days	As Needed
Handoff	Doctor to Doctor	Hospital to PCP team	Hospital to PCP team
DC Summary	Phone AND Fax	EHR or Fax	EHR or Fax
Interventions Prior to discharge	• Schedule a face-to-face follow-up visit within 48 hours of discharge. Care teams should assess whether an office visit or Home Health care is the best option for the patient. • If a Home Health care visit is scheduled in the first 48 hours, an office visit might be slightly later but must also be scheduled within 5 days. • Initiate supportive care management programs as indicated (if not provided in primary care or in outpatient specialty clinics (e.g. heart failure, stroke clinics) • Provide 24/7 phone number for advice about questions and concerns. • Initiate a referral to social services and community resources as needed.	• Schedule a follow-up phone call within 48 hours of discharge and schedule a physician office visit within 5-7 days. • Initiate in-home services (home health, palliative/ hospice care or home care) or transitional care services as needed. • Provide 24/7 phone number for advice about questions and concerns. • Initiate a referral to social services and community resources as needed.	• Schedule a follow-up phone call within 48 hours of discharge and schedule a physician office visit. • Provide 24/7 phone number for advice about questions and concerns. • Initiate a referral to social services and community resources as needed.

This Triage Grid above was adapted by local physicians and hospitals with evidence from the Institute for Healthcare Improvement (IHI) toolkit. Adapted from: Rutherford, P. et al. *How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations*. Cambridge, MA: Institute for Healthcare Improvement; June 2012. www.IHI.org.

Tool 1.2: The 8Ps: Assessing Your Patients Risk for Adverse Events after Discharge

The 8Ps:
Assessing Your Patient's Risk For Adverse Events After Discharge

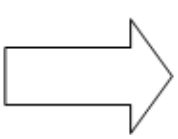
Risk Assessment: 8P Screening Tool (Check all that apply.)	Risk Specific Intervention	Signature of individual responsible for insuring intervention administered
Problem medications (anticoagulants, insulin, oral hypoglycemic agents, aspirin & clopidogrel dual therapy, digoxin, narcotics) ☐	☐ Medication specific education using Teach Back provided to patient and caregiver ☐ Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin) ☐ Specific strategies for managing adverse drug events reviewed with patient/caregiver ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Psychological (depression screen positive or h/o depression diagnosis) ☐	☐ Assessment of need for psychiatric aftercare if not in place ☐ Communication with aftercare providers, highlighting this issue if new ☐ Involvement/awareness of support network insured	
Principal diagnosis (cancer, stroke, DM, COPD, heart failure) ☐	☐ Review of national discharge guidelines, where available ☐ Disease specific education using Teach Back with patient/caregiver ☐ Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms ☐ Discuss goals of care and chronic illness model discussed with patient/caregiver	
Polypharmacy (≥5 more routine meds) ☐	☐ Elimination of unnecessary medications ☐ Simplification of medication scheduling to improve adherence ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Poor health literacy (inability to do Teach Back) ☐	☐ Committed caregiver involved in planning/administration of all general and risk specific interventions ☐ Aftercare plan education using Teach Back provided to patient and caregiver ☐ Link to community resources for additional patient/caregiver support ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Patient support (absence of caregiver to assist with discharge and home care) ☐	☐ Follow-up phone call at 72 hours to assess condition, adherence and complications ☐ Follow-up appointment with aftercare medical provider within 7 days ☐ Involvement of home care providers of services with clear communications of discharge plan to those providers	
Prior hospitalization (non-elective; in last 6 months) ☐	☐ Review reasons for re-hospitalization in context of prior hospitalization ☐ Follow-up phone call at 72 hours to assess condition, adherence and complications ☐ Follow-up appointment with aftercare medical provider within 7 days	
Palliative care (Would you be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness?) Yes to either: ☐	☐ Assess need for palliative care services ☐ Identify goals of care and therapeutic options ☐ Communicate prognosis with patient/family/caregiver ☐ Assess and address bothersome symptoms ☐ Identify services or benefits available to patients based on advanced disease status ☐ Discuss with patient/family/caregiver role of palliative care services and benefits and services available	

Tool 1.3.a: LACE Readmission Risk Assessment Tool

Step 1. Length of Stay

Length of stay (including day of admission and discharge): _____ days

Length of stay (days)	Score (circle as appropriate)
1	1
2	2
3	3
4-6	4
7-13	5
14 or more	7



L

Step 2. Acuity of Admission

Was the patient admitted to hospital via the emergency department?
If yes, enter "3" in Box A, otherwise enter "0" in Box A

A

Step 3. Comorbidities

Condition (definitions and notes on reverse)	Score (circle as appropriate)
Previous myocardial infarction	+1
Cerebrovascular disease	+1
Peripheral vascular disease	+1
Diabetes without complications	+1
Congestive heart failure	+2
Diabetes with end organ damage	+2
Chronic pulmonary disease	+2
Mild liver disease	+2
Any tumor (including lymphoma or leukemia)	+2
Dementia	+3
Connective tissue disease	+3
AIDS	+4
Moderate or severe liver disease	+4
Metastatic solid tumor	+6
TOTAL	

If the TOTAL score is between 0 and 3 enter the score into Box C. If the score is 4 or higher enter 5 into Box C

C

Step 4. Emergency department visits

How many times has the patient visited an emergency department in the six months prior to admission (not including the emergency department visit immediately preceding the current admission)? _____

Enter this number or 4 (whichever is smaller) in Box E

E

Add numbers in Box L, Box A, Box C, and Box E to generate LACE score and enter into box below. If the patient has a LACE score greater than or equal to 10 the patient can be referred to the virtual ward

LACE

Tool 1.3.b: LACE Readmission Risk Assessment Tool (cont.)

Condition	Definition and/or notes
Previous myocardial infarction	Any previous definite or probable myocardial infarction
Cerebrovascular disease	Any previous stroke or transient ischemic attack (TIA)
Peripheral vascular disease	Intermittent claudication, previous surgery or stenting, gangrene or acute ischemia, untreated abdominal or thoracic aortic aneurysm
Diabetes without microvascular complications	No retinopathy, nephropathy or neuropathy
Congestive heart failure	Any patient with symptomatic CHF whose symptoms have responded to appropriate medications
Diabetes with end organ damage	Diabetes with retinopathy, nephropathy or neuropathy
Chronic pulmonary disease	??
Mild liver disease	Cirrhosis but no portal hypertension (i.e., no varices, no ascites) OR chronic hepatitis
Any tumor (including lymphoma or leukemia)	Solid tumors must have been treated within the last 5 years; includes chronic lymphocytic leukemia (CLL) and polycythemia vera (PV)_
Dementia	Any cognitive deficit??
Connective tissue disease	Systemic lupus erythematosus (SLE), polymyositis, mixed connective tissue disease, moderate to severe rheumatoid arthritis, and polymyalgia rheumatica
AIDS	AIDS-defining opportunistic infection or CD4 < 200
Moderate or severe liver disease	Cirrhosis with portal hypertension (e.g., ascites or variceal bleeding)
Metastatic solid tumor	Any metastatic tumour

Tool 1.4.a: MultiCare Health System Readmission Risk Assessment & Strategies

MultiCare Health System
Readmission Risk Tool*
Intended to guide discharge processes and interventions
v2.0 2013

MultiCare
BetterConnected

	Check the following that are true.	Points
	Age 80 or older	1
	No funding source	1
	More than 4 Chronic Conditions	1
	Active Behavioral / psychiatric health issue	1
	Six or more prescribed medications	1
	Two or more hospitalizations within the past 6 months	1
	Readmitted within 30 days	1
	Inadequate support system	1
	Low health literacy	1
	Documented history of non adherence to the therapeutic regimen	1
	Require assistance with ADL's	1
	Substance / ETOH abuse	1
	CM / MSW / Physician determination	6
	Take the sum of the points and enter the total	

Score	
Low	0 to 2
Medium	3 to 4
High	5 to 6
Intensive	above 6

If you have questions regarding this MHS Readmission Risk Assessment Tool please contact:
Stephanie Mudd
MultiCare Health System
Care Management
253-403-1794

* MHS Readmission Tool based from Mary Naylor's transition care model

Tool 1.4.b: MultiCare Health System Readmission Risk Assessment & Strategies (cont.)

MultiCare Health System
Care Management Department

MultiCare BetterConnected

Care Management Strategies for Risk of Readmissions

Intensive Risk	**High Risk**
1. Care Conference	1. Care Conference Recommended
2. Evaluate SNF vs HH	2. Evaluate SNF vs HH
3. Referrals	3. Referrals to consider
Palliative	Palliative
MSW	MSW
Pharmacy Med Rec	Community Referrals
Community Referrals	HF Clinic, RCCP, COPD Focus, Pulmonary Clinic etc
HF Clinic, RCCP, COPD Focus, Pulmonary Clinic etc	4. Follow up appointment made with PCP
4. Follow up appoitment with PCP	Goal: Appointment within 2 to 4 days
Goal: Appointment within 2 days	5. CM Discharge Summary Completed
5. CM Discharge Summary Completed	
Medium Risk	**Low Risk**
1. SNF vs HH	1. SNF vs HH
2. Community Referrals	2. Community Referrals
HF Clinic, RCCP, COPD Focus, Pulmonary Clinic etc	HF Clinic, RCCP, COPD Focus, Pulmonary Clinic etc
3. Follow up appointment made by patient unless cognitivaly impaired	3. PCP appointment made by patient
Goal : Appointment within 5-7 day	Goal: Appointment within 7 - 10 days
4. CM Discharge Summary suggested	4. CM No Discharge Summary Required

Tool 1.5.a: Rockwood Health System Care Coordination Risk Assessment

Patient Name_____
MR#_____

DIRECTIONS: Complete this assessment at Start of Care, at Resumption and at Recertification

Emergent Care	**Points**	**Emergent Care**	**SCORE**
use during the previous 6 months	0	No emergent care use of a hospital ED	
	1	1-2 emergent visits to a hospital ED	
(Related to the primary or co-morbidity diagnosis	2	3-4 emergent visits to a hospital ED	
for home health services)	3	5 or more emergent visits to a hospital ED	
Hospitalizations	**Points**	**Hospitalization**	**SCORE**
within the past 6 months	0	No hospitalizations	
	1	1-2 hospitalizations	
(Related to the primary or co-morbidity diagnosis	2	3-4 hospitalizations	
for home health services)	3	5 or more hospitalizations	
High Risk Diagnosis	**Points**	**High Risk Diagnosis**	**SCORE**
	1 point for each	• CAD/AMI	
		• CHF	
Primary / secondary	Diagnosis	• COPD	
		• DM	
		• Pneumonia	
Co-Morbidity Diagnosis	**Points**	**Co-Morbidity Dx**	**SCORE**
	0	No co-morbidities	
	1	1-2 co-morbidities	
	2	3-4 co-morbidities	
	3	5 or more co-morbidities	
Severity of Illness-	**Points**	**Co-Morbidity Dx**	**SCORE**
Impact on ADL	0	**Asymptomatic:** No limitations on activities of daily living	
	1	**Minimal Severity:** Symptoms present but little limitations on activities of daily living	
	2	**Mild Severity:** Symptoms present daily and cause limitations on activities of daily living	
	3	**High Severity**: Symptoms present most of the day and cause a significant impact on activities of daily living	

Tool 1.5.b: Rockwood Health System Care Coordination Risk Assessment (cont.)

Risk Characteristics	Points	Risk Characteristics	SCORE
Specific to the patient's mental and physical status, home environment, social support, lifestyle and use of the health care system	1 point for each characteristic **CHECK ALL THAT APPLY** Maximum = 13	• Lives alone (MO340) • No primary caregiver identified (MO360) • Home environment not conducive to home health • Discharge from an acute care hospital ((MO175) • Patient demonstrates confusion (3 or above on MO570) • Severe anxiety level (2 or above on MO580) • Surgical wounds (MO440, MO476, MO484) • Stage 3-4 pressure ulcer (MO440, MO476) • Urinary catheter (MO520) • Treatment regime complex for patient's ability to manage • Takes more than 8 medications (prescribed and OTC) • 3 or more physicians ordering medications or treatments • History of inconsistent follow-up with medical provider	
TOTAL SCORE			

Risk Assessment Follow up

High Risk= Score: >11
Enrolled in care coordination
Phone Calls
1. Post discharge call within 12-24 hrs. following discharge
2. Following provider visit
3. 2-3 times per week as needed for 30 days

Provider Follow up
1. Post discharge office visit within 24-48 hrs. following discharge
2. Additional follow up visit every 1-2 weeks as needed per provider discretion

Re-assess after 30 days

Moderate Risk= Score: 8-10
Enrolled in care coordination if needed
Phone Calls
1. Post discharge call within 48hrs following discharge
2. Following provider visit
3. 1-2 times per week as needed

Provider Follow Up
1. Post discharge office visit within 5 days following discharge
2. Additional follow up visits as needed per provider discretion

Re-assess after 30 days

Low Risk=Score: 0-7
Enrollment in care coordination and reassessment per clinician discretion
Phone Calls
1. Post discharge call within 7 days following discharge
2. Follow up calls as needed

Provider Follow Up
1. Post discharge visit as needed per provider discretion

Tool 2: Primary Care Provider Notification

Patient Information

Patient Name: _____ Date of Birth: ___/___/___ Gender: Male/Female

Admission Information

Visit/Admission Date: ___/___/___

Admit reason/Anticipated diagnosis/Admit diagnosis: _____

Attending Name and Number: _____ Location: _____

Additional Contact Name and Number: _____

"If you are not this patient's Primary Care Provider or you believe you have received this notice in error, please call/fax to (xxx) xxx-xxxx."

Tool 3: Plan of Care

Name: _____

Date of Birth: _____

Address: _____

Code Status: _____

Language: _____

Interpreter required: Yes/No

Primary Care Provider: _____

Other Providers Involved in Care: _____

Hospitalizations in last 12 months: _____ ER Visits in last 6 months: _____

Diagnoses: _____

Allergies: _____

Medications: _____

Significant Medical Problems and Clinical History: _____

_____

Social History: _____

Barriers to Self-Care: _____

_____

Living situation: _____

Lives with: _____

Housing situation concerns – Yes/No

Have dependable transportation – Yes /No

Have someone who can help – Yes/ No

Tool 3: Plan of Care (cont.)

Safety/Risk Assessment: _____
Mental health status including cognitive function: _____
Cultural needs, preferences or limitations: _____
Caregiver and/or support system: _____

Plan of Care

- Problems:
- Barriers:
- Short and Long Term Goals with Target Dates:
- Interventions Planned:
- Progress toward Goal:
- Goal Achieved Date:

Tool 4: My Medication List

Medication Name	Dose	Frequency	Comment Continued/Altered/New/Discontinued	Reason for Taking Medication

Tool 5: Social/Resource Barriers Assessment

- Number of Admissions: _____
- Advance Care Plan: _____
- Current Living Situation: _____
- Recent Mental Health Services: _____
- Recent Housing: _____
- Current Employment: _____
- Source of Income: _____
- Social Background: _____
- Education: _____
- Substance Abuse Brief Assessment: _____
- Patient's Functional Limitations: _____
- Assessment of Social Functioning: _____
- Anticipated Social Work Needs/Interventions: _____
- Potential Discharge Issues; preliminary discharge plan: _____
- Patient's biggest concerns post-discharge: _____