CLINICAL GUIDELINE:

Ambulatory Follow-Up Within 7 Days of Discharge

Physician Clinical Integration Network, LLC

Scope

Increased risk of patient harm has been identified during the transition of care between hospital discharge and follow-up in the outpatient setting. One in five patients may experience an adverse event during the first few weeks following hospital discharge [1]. According to a national study by the Center for Studying Health System Change, one in three adult patients discharged from a hospital does not see a physician within 30 days [10].

To improve the quality of patient care during this transition, this guideline focuses on the importance of ambulatory follow-up within 7 days post-hospital discharge and care intervention models proven successful in providing high quality of care.

Population Included

Adults >18 years of age discharged from a hospital setting

Exclusions

Maternity & newborn admissions

Guidance

The PCIN Quality Committee and its designees reviewed the available information in the medical literature and societal guidelines, as well as information derived from their clinical practices, and results from the PCIN analytics team on ambulatory follow-up within 7 days of discharge to devise these guidelines.

Recommendations

- ✓ Recommendations supporting ambulatory follow-up within 7 days of discharge:
  - The patient's discharge instructions to include (Figure 1):
    - Problem list at the time of discharge
    - Preset follow-up appointments, including name/address of provider, date/time of appointment and reason for visit
    - Preset follow-up appointments for tests/procedures including location and date/time
    - Important contact information including primary care provider, hospital doctor, visiting nurse (if applicable) and pharmacy
  - The teach-back approach should be used to ensure patient understanding of education, including follow-up appointments.
  - Discharge summaries should be sent directly to the patient's primary care physician and next care setting within 24 hours.
  - A phone call should be placed to the patient within one to three days post-hospital discharge by an ambulatory nurse, case manager, social worker or other health care provider (Figure 2).
  - Follow-up appointments (scheduled before the patient is discharged):
    - High-risk patients: within 48-72 hours
    - Moderate-risk patients: within 7 days
    - Low-risk patients: as deemed necessary by the attending physician

Rationale

Research focusing on ambulatory follow-up within 7 days of discharge primarily focuses on the effectiveness of reducing 30-day hospital readmission rates, a primary healthcare quality indicator. In a study of Medicare Advantage patients discharged from 14 Kaiser Permanente Foundation hospitals between 2011 and 2014, it was determined that patients who completed any outpatient visit within 7 days had a 12% to 24% lower risk for a 30-day readmission [2].

While a post-discharge visit heightens the awareness of the patient's immediate post-discharge needs, patient acuity and comorbidities have a significant effect on readmissions. Tong et al. determined that while follow-up visits were associated with lower readmission risk for most patients, higher hazard ratios resulted in a higher probability of readmissions. Many of these patients had complicated conditions with frequent hospitalizations, indicating higher risk patients may need follow-up extending beyond an office visit [4]. It is estimated approximately one half of all Medicare and Medicaid patients do not receive outpatient follow-up prior to readmission [7].

Created under the Patient Protection and Affordable Care Act, Medicare initiated the Hospital Readmission Reduction Program (HRRP), imposing reimbursement penalties on hospitals with more than the expected readmission rates for patients with heart failure, acute myocardial infarction and community-acquired pneumonia. Medicare also imposed penalties on accountable care organizations (ACOs) to increase their collaboration with hospitals in reducing these readmissions [3]. As a result, Centers for Medicare and Medicaid Services (CMS) began funding programs designed to improve transition of care, such as the Community-based Care Transitions Program (CCTP), aimed at providing services to patients with problems requiring moderate to high medical decision-making [5].

In January 2013, Medicare implemented payment incentives for follow-up appointments within 7 and 14 days of discharge to ensure timely interventions. In response to this proposal, several transitional care models have emerged with little direction as to what is best practice. Research by C Jackson et al determined follow-up within 7 days resulted in a greater than 20% baseline risk of readmissions for patients with multiple chronic conditions, concluding highest risk patients would benefit from transitional care resources [7]. Following the implementation of a team-based Transitions Care Management intervention, it was determined contact by nursing and/or a pharmacist soon after hospital discharge and prompt follow-up with the primary care physician for clinical assessment contributed to a readmission rate of 5.3%, far lower than the national average of 18.4% [11].

The Following Models have been Successful in Reducing Readmission Rates:

Transitional Care Model (Figure 3)

The Transitional Care Model provides comprehensive discharge planning and follow up post-discharge for chronically-ill, high-risk, older adults, resulting in the reduction of hospital readmissions, improved health outcomes, enhanced patient satisfaction and total health care cost savings [6]. This model, managed by a transitional care nurse, focuses on enhancing patient/caregiver understanding, facilitating patient safe-management, and overseeing medication management [9].

Care Transitions Program

This model, likened to the Transitional Care Model, was developed to empower patients and caregivers with the use of a "transition coach." The transition coach assists with medication reconciliation and self-management, facilitating transfer of information, timely outpatient follow-up, and ensuring the patient understands how to respond to indicators of a worsening condition. While a randomized control trial demonstrated a reduction in hospital readmissions, there are no conclusive results identified [9].

Re-Engineered Discharge (RED)

Developed by researchers at the Boston University Medical Center (BUMC), the Re-Engineered Discharge (RED) was developed, reporting a decrease of 25% in 30-day readmissions, a decrease in Emergency Department use from 24% to 16%, and a 33.9% lower observed cost. RED consists of the following 12 actions:

1. Ascertain need for and obtain language assistance;
2. Make appointments for follow-up care (e.g., medical appointments, post-discharge tests/labs);
3. Plan for the follow-up of results from tests or labs pending at discharge;
4. Organize post-discharge outpatient services and medical equipment;
5. Identify the correct medicines and a plan for the patient to obtain them;

6. Reconcile the discharge plan with national guidelines;
7. Teach a written discharge plan the patient can understand;
8. Educate the patient about his or her diagnosis and medicines;
9. Review with the patient what to do if a problem arises;
10. Assess the degree of the patient's understanding of the discharge plan;
11. Expedite transmission of the discharge summary to clinicians accepting care of the patient; and
12. Provide telephone reinforcement of the discharge plan.

RED has been accepted as the National Qualifications Framework Safe Practice and endorsed by the Institute for Healthcare Improvement, The Leapfrog Group for Patient Safety, and CMS. RED improves return on investment by reducing costs by $412 per patient, allows for a higher level of physician billing for discharge and improves relationships with ambulatory providers [8].

Better Outcomes by Optimizing Safe Transitions (BOOST)

BOOST is a national initiative developed by the Society of Hospital Medicine involving the following evidence-based clinical interventions:

- Identification of patients at high-risk upon admission
- Targets risk-specific situations
- Improving communication between inpatient and outpatient providers
- Improving patient/caregiver education using the teach-back method
- Ensuring timely follow-up post-hospital discharge

Pilot studies of this model resulted in a 14% reduction in 30-day readmission rates, and it was awarded the 2011 John M. Eisenberg Award for Innovation in Patient Safety and Quality [9].

BOOST involves a culture change and a high degree of quality program implementation commitment, taking 12-24 months to fully establish the program.

The following "tools" provide the foundation of an ideal care transition:

- Assessment of patient risk for adverse events after discharge utilizing the "8P's":
  - Problems with medications
  - Psychological (depression screening)
  - Principal diagnosis or reason for hospitalization
  - Physical limitations
  - Poor health literacy
  - Poor social support
  - Prior hospitalization
  - Palliative care needs
- Assessing the patient's preparedness for transitioning out of the hospital using the "General Assessment of Preparedness" (GAP), designed to identify patient's risks during transition
- Patient-centered written discharge instructions (Figure 1)
- Teach-back approach to patient education
- Follow-up telephone calls (Figure 2) within 72 hours of discharge using the teach-back approach, addressing the following:
  - Clinical Status: general clinical conditions since discharge
  - Medications
  - Follow-up plans (pending tests, procedures, services and follow-up appointments)
- Follow-up appointments (scheduled before the patient is discharged):
  - High-risk patients: face-to-face visits with the physician within 48 - 72 hours
  - Moderate-risk patients: follow-up appointment with the physician within 7 days
  - Low-risk patients: follow-up appointment as deemed necessary by the attending physician
- Interprofessional rounds during hospitalization
- Post-acute care transitions
- Medication reconciliation

BOOST embraces "patient-centered care", supporting and engaging patients in medical decision making. Ongoing research and expert input by The Joint Commission, the National Quality Forum, the Institute for Healthcare Improvement and the Agency for Healthcare Research and Quality makes this the model of choice for more than 180 hospitals [10].

Key Strategies to Improve the "Ambulatory Follow-Up Within 7 Days of Discharge"

Each of the above transition of care models has several key strategies in common that can be used to facilitate patient follow-up within 7 days and reduce the risk of readmission:

- Engage a team of key stakeholders that includes patients, caregivers, hospital staff, community physicians, advance practice providers and post-acute care facilities/services
- Daily interdisciplinary communication and care coordination, emphasizing care planning, discharge planning and safety issues
- Standardize transition plans, procedures and forms (i.e., discharge summary templates) that include the following:
  - Pertinent diagnoses
  - Active issues
  - Reconciled medication list with changes highlighted
  - Important test results and consultations
  - Pending test results
  - Follow-up plans and required consultations
  - Signs/symptoms possible for a worsening condition and actions the patient can take to respond
- Discharge summaries should be sent directly to the patient's primary care physician or next setting
- Provide a discharge plan to the patient that is easy for them to understand (i.e., language and educational level)
- Provide education using the teach-back method
- Follow up and coordinate support in a timely manner with appointments made prior to hospital discharge
- The patient should be called within one to three days post-hospital discharge by a case manager, social worker, nurse or other health care provider [9]

While all strategies affect readmission rates, following up and coordinating support in a timely manner with appointments directly affects the measure of "Ambulatory Follow-Up Within 7 Days of Discharge." A study focusing on ambulatory follow-up supported the value of post-discharge calls by nurses from the primary care practice, improving post-hospital care through the identification of early clinical and coordination of care issues including, but not limited to, the follow-up visit [12].

References

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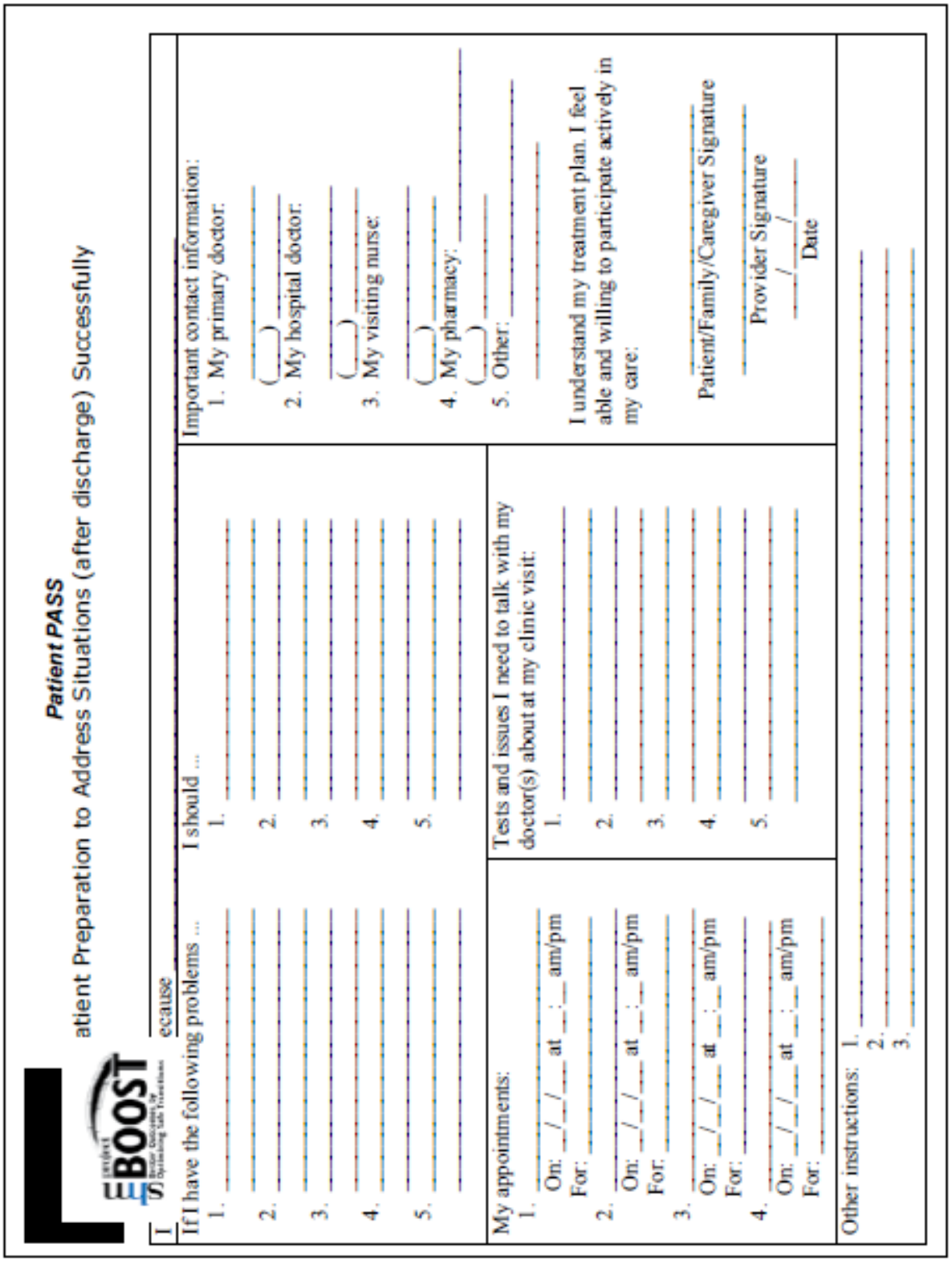
13. AHRQ.Post discharge Follow-up Phone Call Documentation Form. Retrieved from: https://www.ahrq.gov/sites/default/files/publications/files/postdiscalldoc.pdf

Appendix

Figure 1: Transition Record and Discharge Patient Education Tool (DPET) [10]



Patient PASS

atient Preparation to Address Situations (after discharge) Successfully

I _____

ecause _____

If I have the following problems ...	I should ...	Important contact information:
1. _____	1. _____	1. My primary doctor: _____ (___) _____
2. _____	2. _____	2. My hospital doctor: _____ (___) _____
3. _____	3. _____	3. My visiting nurse: _____ (___) _____
4. _____	4. _____	4. My pharmacy: _____ (___) _____
5. _____	5. _____	5. Other: _____
My appointments:	Tests and issues I need to talk with my doctor(s) about at my clinic visit:	I understand my treatment plan. I feel able and willing to participate actively in my care:
1. _____ On: __/__/___ at __:__ am/pm For: _____	1. _____	_____ Patient/Family/Caregiver Signature
2. _____ On: __/__/___ at __:__ am/pm For: _____	2. _____	_____ Provider Signature
3. _____ On: __/__/___ at __:__ am/pm For: _____	3. _____	___/___/___ Date
4. _____ On: __/__/___ at __:__ am/pm For: _____	4. _____	
	5. _____	

Other instructions: 1. _____
2. _____
3. _____

Coffey C, Greenwald J, Budnitz T, Williams M. Project Boost Implementation Guide Second Edition. (2013). Retrieved from: https://shm.hospitalmedicine.org/acton/attachment/25526/f-04f0/1/-/-/-/-/BOOST%20Guide%20Second%20Edition.pdf

Figure 2: Post-Discharge Follow-Up Phone Call Documentation Form [13]

Postdischarge Followup Phone Call Documentation Form

Patient name: _____

Caregiver(s) name(s): _____

Relationship to patient: _____

Notes: _____

Discharge date: _____

Principal discharge diagnosis: _____

Interpreter needed? Y N Language/Dialect: _____

.....

Prior to phone call:

Review:

Health history
Medicine lists for consistency
Medicine list for appropriate dosing, drug-drug and drug-food interactions, and major side effects
Contact sheet
DE notes
Discharge summary and AHCP

Call Completed: Y N

With whom (patient, caregiver, both): _____

Number of hours between discharge and phone call: _____

Consultations (if any) made prior to phone call:

- ❑ None
- ❑ Called MD
- ❑ Called DE
- ❑ Called outpatient pharmacy
- ❑ Other: _____

If any consultations, note to whom you spoke, regarding what, and with what outcome:

_____

_____

AHRQ. Post discharge Follow-up Phone Call Documentation Form. Retrieved from: http://www.ahrq.gov/sites/default/files/publications/files/postdiscalldoc.pdf

Figure 2 (continued)

Phone Call Attempts

Patient/Proxy

Phone Call #1: Date & Time:_____ Reached: Yes/No

If No (circle one): ans. machine/no answer/not home/declined/busy/rescheduled/other:

Phone Call #2: Date & Time:_____ Reached: Yes/No

If No (circle one): ans. machine/no answer/not home/declined/busy/rescheduled/other:

Phone Call #3: Date & Time:_____ Reached: Yes/No

If No (circle one): ans. machine/no answer/not home/declined/busy/rescheduled/other:

Phone Call #4: Date & Time:_____ Reached: Yes/No

Alternate Contact 1

Phone Call #1: Date & Time:_____ Reached: Yes/No

If No (circle one): ans. machine/no answer/not home/declined to provide information/busy/other:

Phone Call #2: Date & Time:_____ Reached: Yes/No

If No (circle one): ans. machine/no answer/not home/declined to provide information/busy/other:

Phone Call #3: Date & Time:_____ Reached: Yes/No

If No (circle one): ans. machine/no answer/not home/declined to provide information/busy/other:

Phone Call #4: Date & Time:_____ Reached: Yes/No

Alternate Contact 2

Phone Call #1: Date & Time:_____ Reached: Yes/No

If No (circle one): ans. machine/no answer/not home/declined to provide information/busy/other:

Phone Call #2: Date & Time:_____ Reached: Yes/No

If No (circle one): ans. machine/no answer/not home/declined to provide information/busy/other:

Phone Call #3: Date & Time:_____ Reached: Yes/No

If No (circle one): ans. machine/no answer/not home/declined to provide information/busy/other:

Phone Call #4: Date & Time:_____ Reached: Yes/No

AHRQ. Post discharge Follow-up Phone Call Documentation Form. Retrieved from: http://www.ahrq.gov/sites/default/files/publications/files/postdiscalldoc.pdf

Figure 2 (continued)

A. Diagnosis and Health Status

Ask patient about his or her diagnosis and comorbidities

- ❑ Patient confirmed understanding
- ❑ Further instruction was needed

If primary condition has worsened:

What, if any, actions had the patient taken?

- ❑ Returned to see his/her clinician (name): _____
- ❑ Called/contacted his/her clinician (name): _____
- ❑ Gone to the ER/urgent care (specify): _____
- ❑ Gone to another hospital/MD (name): _____
- ❑ Spoken with visiting nurse (name): _____
- ❑ Other: _____
- ❑ What, if any, recommendations, teaching, or interventions did you provide?

If new problem since discharge:

Had the patient:

- ❑ Contacted or seen clinician? (name): _____
- ❑ Gone to the ER/urgent care? (specify):_____
- ❑ Gone to another hospital/MD? (name): _____
- ❑ Spoken with visiting nurse? (name):_____
- ❑ Other?:_____

Following the conversation about the current state of the patient's medical status:

What recommendations did you make?

- ❑ Advised to call clinician (name): _____
- ❑ Advised to go to the ED
- ❑ Advised to call DE (name):_____
- ❑ Advised to call specialist physician (name):_____
- ❑ Other: _____

What followup actions did you take?

- ❑ Called clinician and called patient/caregiver back
- ❑ Called DE and called patient/caregiver back
- ❑ Other:

AHRQ. Post discharge Follow-up Phone Call Documentation Form. Retrieved from: http://www.ahrq.gov/sites/default/files/publications/files/postdiscalldoc.pdf

Figure 2 (continued)

B. Medicines

Document any medicines patient is taking that are **NOT** on AHCP and discharge summary:

_____

Document **problems** with medicines that are on the AHCP and discharge summary (e.g., has not obtained, is not taking correctly, has concerns, including side effects):

Medicine 1: _____

Problem: _____

- ❑ Intentional nonadherence
- ❑ Inadvertent nonadherence
- ❑ System/provider error

What recommendation did you make to the patient/caregiver?

- ❑ No change needed in discharge plan as it relates to the drug therapy
- ❑ Educated patient/caregiver on proper administration, what to do about side effects, etc.
- ❑ Advised to call PCP
- ❑ Advised to go to the ED
- ❑ Advised to call DE
- ❑ Advised to call specialist physician
- ❑ Other: _____

What followup action did you take?

- ❑ Called hospital physician and called patient/caregiver back
- ❑ Called DE and called patient/caregiver back
- ❑ Called outpatient pharmacy and called patient/caregiver back
- ❑ Other: _____

Medicine 2:_____

Problem: _____

- ❑ Intentional nonadherence
- ❑ Inadvertent nonadherence
- ❑ System/provider error

What recommendation did you make to the patient/caregiver?

- ❑ No change needed in discharge plan as it relates to the drug therapy
- ❑ Educated patient/caregiver on proper administration, what to do about side effects, etc.
- ❑ Advised to call PCP

AHRQ. Post discharge Follow-up Phone Call Documentation Form. Retrieved from: http://www.ahrq.gov/sites/default/files/publications/files/postdiscalldoc.pdf

Figure 2 (continued)

- ❑ Advised to go to the ED
- ❑ Advised to call DE
- ❑ Advised to call specialist physician
- ❑ Other: _____

What followup action did you take?

- ❑ Called hospital physician and called patient/caregiver back
- ❑ Called DE and called patient/caregiver back
- ❑ Called outpatient pharmacy and called patient/caregiver back
- ❑ Other: _____

Medicine 3:_____

Problem: _____

- ❑ Intentional nonadherence
- ❑ Inadvertent nonadherence
- ❑ System/provider error

What recommendation did you make to the patient/caregiver?

- ❑ No change needed in discharge plan as it relates to the drug therapy
- ❑ Educated patient/caregiver on proper administration, what to do about side effects, etc.
- ❑ Advised to call PCP
- ❑ Advised to go to the ED
- ❑ Advised to call DE
- ❑ Advised to call specialist physician
- ❑ Other: _____

What followup action did you take?

- ❑ Called hospital physician and called patient/caregiver back
- ❑ Called DE and called patient/caregiver back
- ❑ Called outpatient pharmacy and called patient/caregiver back
- ❑ Other: _____

AHRQ. Post discharge Follow-up Phone Call Documentation Form. Retrieved from: http://www.ahrq.gov/sites/default/files/publications/files/postdiscalldoc.pdf

Figure 2 (continued)

C. Clarification of Appointments

Potential barriers to attendance identified: ❑ Y ❑ N

List: _____

Potential solutions/resources identified: ❑ Y ❑ N

List: _____

Alternative plan made: ❑ Y ❑ N Details: _____

Clinician/DE informed: ❑ Y ❑ N Details: _____

D. Coordination of Postdischarge Home Services (if applicable)

Document any postdischarge services that need to be checked on and who will be doing that (caller/patient/caregiver).

E. Problems

Did patient/caregiver know what constituted an emergency and what to do if a nonemergent problem arose?

❑ Yes ❑ No

If no, document source of confusion:

F. Additional Notes

G. Time

Time for reviewing information prior to phone call: _____

Time for missed calls/attempts: _____

Time for initial phone call: _____

Time for talking to other health care providers: _____

Time for followup/subsequent phone calls to patient: _____

Time for speaking with family or caregivers: _____

Total time spent: _____

Caller's Signature: _____

AHRQ. Post discharge Follow-up Phone Call Documentation Form. Retrieved from: http://www.ahrq.gov/sites/default/files/publications/files/postdiscalldoc.pdf

Figure 3: Transitional Care Model

Naylor MD. Advancing High Value Transitional Care: The Central Role of Nursing and Its Leadership. Nursing Administration Quarterly. 2012;36(2): 115-126

Approved: 2/7/2020