Project SAFEST: Scheduling Ambulatory Follow-up for Effective and Secure Transitions

Division of Hospital Medicine
UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

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Background

- UCH utilizes Care Coordinators (CCs) who assist in scheduling the appropriate post hospitalization follow-up care for patients
- Significant variation exists in the current process to secure appointments for patients
- With sicker patients, a push for shorter lengths of stay and provider discontinuity across care settings, the post-discharge period is vulnerable time for patients, leading to post-discharge complications
- Currently, only 77.6% of hospitalized patients with Medicaid have a scheduled follow-up appointment within 30 days of discharge
- 11.2% of patients with Medicaid have no follow-up scheduled within any time frame
- Scheduled follow-up appointments is a Hospital Transformation Program (HTP) metric tied to Medicaid supplemental payments for UCH

Project Aim

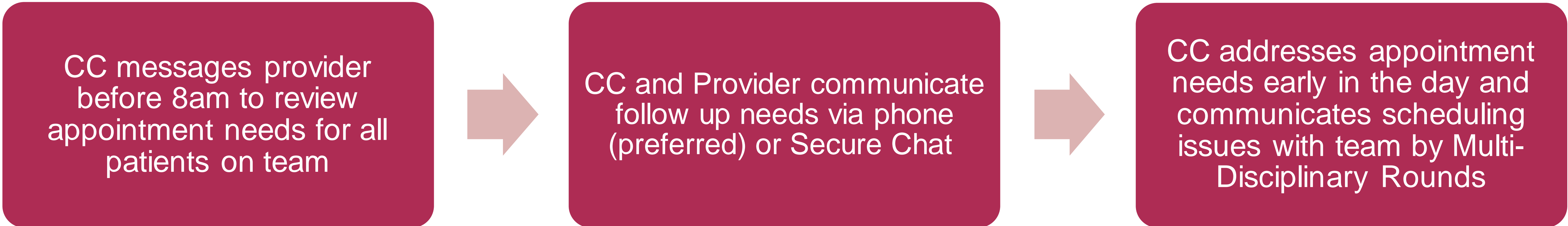
- Increase the percent of documented scheduled clinician follow-up appointments within 30 days of discharge by 15% for patients with Medicaid discharged to home from an inpatient encounter by June 2022

Root Cause Analysis and Measures

- Performed root cause affinity diagrams with CCs and inpatient providers to both identify barriers and then generate solutions to securing follow-up appointments at discharge
- Created process maps of effective CCs workflow
- Outcome measure: documented scheduled clinician follow-up appointments within 30 days for patients with Medicaid discharged to home from an inpatient encounter
- Balancing measures: 7-, 14-, and 30-day readmissions; 7-, 14-, 30-day emergency department (ED) visits, and CC and provider satisfaction and workload

Intervention

- Created first PDSA cycle to streamline CC-provider communication on appointment needs with standardized morning check-in



Results

- Figure 1 shows pre- and post-intervention data with regards to the number of appointments scheduled for both pilot and non-pilot teams while Figure 2 outlines 30-day readmission rates and ED visits for those patients who had an appointment

Average Number of Appointments Made Across Teams	30-Day Appointment	
	No	Yes
Pre-Intervention Average for All Teams	328 (22.4%)	1139 (77.6%)
Pilot Teams	85 (21.6%)	309 (78.4%)
Non-Pilot Teams	243 (22.6%)	830 (77.4%)
Post-Intervention Average for All Teams	392 (27.2%)	1047 (72.8%)
Pilot Teams	69 (26.8%)	188 (73.1%)
Non-Pilot Teams	323 (27.3%)	859 (72.7%)

Figure 1: Pre- and post-intervention number of scheduled 30-day post-discharge appointments for patients with Medicaid

Rates for patients who had a post-discharge appointment scheduled	30-Day Readmission		30-Day ED Return	
	No	Yes	No	Yes
Pre-intervention Average for All Teams	910 (79.9%)	229 (20.1%)	909 (79.8%)	230 (20.2%)
Pilot Teams	253 (81.9%)	56 (18.1%)	242 (78.3%)	67 (21.7%)
Non-Pilot Teams	657 (79.2%)	173 (20.8%)	667 (80.4%)	163 (19.6%)
Post-intervention Average for All Teams	844 (80.6%)	203 (19.4%)	847 (80.9%)	200 (19.1%)
Pilot Teams	156 (83%)	32 (17%)	154 (81.9%)	34 (18.1%)
Non-Pilot Teams	688 (80.1%)	171 (19.9%)	693 (80.7%)	166 (19.3%)

Figure 2: Pre- and post-intervention 30-day readmissions and 30-day ED return for patients who had a 30-day post-discharge appointment scheduled

- Most providers (16 out of 21) felt this intervention had a neutral to positive impact on workload
- 15 out of 21 providers found this intervention at least moderately helpful (5 or greater on a scale of 1-10, with 10 being very helpful)

Discussion

- Our first PDSA cycle did not increase the percent of scheduled follow-up appointments, however participants were overall satisfied with the standardized CC-provider communication
- ED visits and readmissions remained the same for those with scheduled follow up in 30 days
- This first PDSA cycle iteratively demonstrated where barriers lie in the process – lack of standardized communication and documentation standards – which is a focus of future PDSA cycles
- There are confounding variables such as severity of illness that are affecting ED visit and readmission correlations
- Additional data over time from future PDSA cycles are needed to determine statistical significance of interventions

Next steps

- Perform additional PDSA cycles
- Attempt to capture if patients showed to scheduled follow-up appointments
- Improve documentation of the work completed by the CCs to allow both providers and other CCs to understand what has been completed
- Capture barriers to obtaining timely appointments to improve access
- Build stronger health system and ambulatory partnerships

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Acknowledgements: We would like to thank the Division of Hospital Medicine and the University of Colorado Hospital (UCH) for their support in presenting at this conference