Clinical Safety & Effectiveness
Team #2 Cohort # 23

Transitions of Care: The Follow-up Journey

Educating for Quality Improvement & Patient Safety
The (Dream) Team

– Judith Wilber, MD – Hospitalist
– Jack Badawy, MD – Hospitalist
– Melanie Roller, BSHM RN CCM – Manager of Hospital Services
– Oluwatosin Omole, MD – Family Practice PCP, RBG
– Jennifer Herrera, LMSW, Director of Patient Access
– Norma Garza, DRPH, Manager – Health Analytics
– Sherry Martin, M Ed, Program Facilitator

Sponsor: Dr. Leykum – Chief of Internal Medicine
The Problem

Data show that 50% of patients admitted to Internal Medicine teams at University Hospital do not attend post-hospital primary care appointments.
Patients who do not attend a follow-up appointment after hospitalization are 10 TIMES more likely to be readmitted within 30 days.

In patients with high risk of readmission, one readmission may be prevented for every five patients who receive follow-up within 14 days.
OUR GOAL

To improve the quality of care and clarity of information delivered to patients during the transition from the hospital, in order to decrease readmissions.
OUR AIM STATEMENT

The aim of this project is to improve the discharge process by increasing the percentage of successful patient attendance at post-hospital follow-up appointments from 50% to 65% by November 26, 2019.
What is the Ambulatory Care Connections Clinic (ACC)?

A clinic created to follow unfunded and/or medically complicated patients who were believed to be at high risk by the referring physician.

Patients are referred for a post-hospitalization appointment with a medical provider.

- Referred from either the ED or Inpatient care teams
- Can provide appointments with Carelink to assess for eligibility.
Project Milestones

• Team Created August 2018
• AIM statement created September 2018
• Weekly Team Meetings 8/20/18 - Date
• Background Data, Brainstorm Sessions, 8/20/18 - 10/20/18
  • Workflow and Fishbone Analyses
• Baseline data collection 10/29/18 - 11/26/18
• Interventions Implemented 11/26/18 - 12/24/18
• Data Analysis 12/24/18 - 12/31/18
• CS&E Presentation 1/17/19
• Graduation Today!
Baseline Data

Proportion of Patients that Attended Follow-Up Appointments

- **Follow Up Rate**
- **Average**
- **Limits**

Weeks: 10/1/2018, 10/8/2018, 10/15/2018, 10/22/2018

Percentages:
- 0.0000
- 0.1000
- 0.2000
- 0.3000
- 0.4000
- 0.5000
- 0.6000
- 0.7000
Patient presents to UH

Flow Chart

Patient follows up in ACC clinic
<table>
<thead>
<tr>
<th>Goal</th>
<th>Primary Drivers</th>
<th>Interventions</th>
<th>Measure</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase patient follow up rates at clinic after discharge from Internal Medicine services.</td>
<td>Patients do not know when or where their follow up appointment is.</td>
<td>Provide patients a detailed map and how to get to the RBG clinic.</td>
<td>% patients follow up</td>
<td>Team by 11/2019</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Educate providers to make sure date and time is in the access plus note prior to discharge.</td>
<td>% of dates in AP note at time of discharge</td>
<td>Team By 1/2020</td>
</tr>
<tr>
<td></td>
<td>Patients unclear on discharge instructions.</td>
<td>Identify barriers of recently discharged patients by calling patients</td>
<td>Phone Survey</td>
<td>Team By 1/2019</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Highlight the important sections of the discharge instructions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Follow up appointments too far out.</td>
<td>Access plus to focus on scheduling appointments 7-10 days after discharge.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Collected lists of patients discharged from IM services with ACC appts - weekly.
- Collected lists of these patients who attended appointments at the ACC over time to calculate % Follow-Up - weekly.
- Utilized validated survey to call patients discharged from IM services with ACC appts to assess understanding of discharge instructions and follow up appointments - ongoing.
**Modified Three-Item Care Transitions Measure (National Quality Forum)**

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Don't Know/Don't Remember/Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2</td>
<td>When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3</td>
<td>The hospital staff clearly explained my follow-up physician visit, to include the time, date, and location.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4</td>
<td>I had a good understanding of how to contact the clinic to change my follow-up appointment.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5</td>
<td>When I left the hospital, I clearly understood the importance of going to the follow up appointment.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6</td>
<td>I had a good understanding of the cost of my follow-up physician visit.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7</td>
<td>What one thing could have helped you understand the discharge instructions more clearly?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Provide patients with concrete and specific follow up information.
You have been given an appointment in the Ambulatory Connections Clinic. In this appointment, you will receive follow-up medical care, and can meet with representatives to see if you qualify for the Carelink program.

Ud. ha sido programado para una cita en la Clínica Ambulatoria. En esta cita Ud. recibirá seguimiento médico y podrá visitar con un representante para ver si califica para el programa de Carelink.

**Ambulatory Connections Clinic**

University Health Center-Downtown  
Robert B. Green Campus

Clinical Pavilion, first (1) floor inside Express Med Clinic  
903 W Martin, San Antonio, Texas 78207  
Phone: (210) 358-9521

**Carelink**

Carelink Enrollment  
Robert B. Green Campus

Historical Building, first (1) floor  
903 W. Martin, San Antonio, Texas 78207  
Phone: (210) 358-3350

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**Public Bus Stops near Robert B Green Campus**

<table>
<thead>
<tr>
<th>Graph</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>3, 17, 24, 75, 93, 275, 276</td>
</tr>
<tr>
<td>B</td>
<td>3, 24, 25, 70, 77, 93, 100</td>
</tr>
<tr>
<td>C</td>
<td>70, 77, 100, 277</td>
</tr>
<tr>
<td>D</td>
<td>3, 20, 76, 79, 86, 289</td>
</tr>
</tbody>
</table>

ViAtans: [www.ViAInfo.net](http://www.ViAInfo.net). Call 210-362-5050 for more information, to apply, or schedule a ride.

Please call (210) 358-9521 to reschedule your appointment if you need a different time and date in order to attend your appointment.

Favor de llamar al (210) 358-9521 para cambiar su cita si no puede asistir a la hora y fecha acordada.
Implementation/PDSA cycles

- Designed Brochure - many editions.
  - Include blow-up map
  - Bilingual
  - VIAtrans info

- Distributed Brochure - Met with Nursing Leadership, Unit Secretaries weekly to debrief.
  - Variation between units
  - Print on brightly colored paper
  - Possible addition for date/time.

- Surveyed patients via phone calls – lessons learned.
  - Non-working numbers
  - Varying time of day
  - Family member answering
Results Graph- SPC chart

Proportion of Patients that Attended Follow-Up Appointments

Intervention Initiation
Patient Survey Data

• Received 9 responses
• 89% agreed having an understanding of their responsibility to manage their health and follow-up visit information
• 100% agreed to understanding the importance of attending their follow-up visit
• Only 44% had a good understanding of the cost
• Comments focused on the need for additional information about funding and the CareLink program
An increase in ACC follow-up rate from 50% -> 65%:
→ increase of (181 patient visits/year) X ($118 per patient visit) = $21,408 increase in clinic revenue per year.

<table>
<thead>
<tr>
<th>Pre-Intervention</th>
<th>Does NOT attend</th>
<th>DOES attend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Percent Patients</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Readmission Rate w/in 30 days</td>
<td>10%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Total Readmission</td>
<td>5%</td>
<td>1.25%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post-Intervention</th>
<th>Does NOT attend</th>
<th>DOES attend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Percent Patients</td>
<td>35%</td>
<td>65%</td>
</tr>
<tr>
<td>Readmission Rate w/in 30 days</td>
<td>10%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Total Readmission</td>
<td>3.5%</td>
<td>1.63%</td>
</tr>
</tbody>
</table>

Total Readmit Rate – 6.25% = 148 patients.

Total Readmit Rate – 5.1% = 122 patients.

Avg cost of readmission per patient - $4732.

Decrease 26 patients x $4732 = $123,032 per year savings in non-reimbursed costs to University Hospital.
Decreasing Readmission Penalties

• Based on current data, increasing OP follow-up rates would remedy actual and potential readmission penalties

• CMS Readmission Reduction Program
  – Medicare actual 2018 penalty of $575,000
  – Medicaid potential penalty of $700,000

• Decreasing re-admission rates, will decrease future penalties.

• Improving the quality of care, patient safety, and health system efficiency 1 patient at a time.
Next Steps

Develop the team to continue distribution of intervention, continue PDSA cycles, add cost information.

Decrease burden of data collection process for more frequent analysis of data.

Repeat survey bedside nurses regarding patient reception, logistics of implementation, suggested edits.
Future Goals

- Collaborate with nursing managers on units to which Medicine services admit – future expansion of brochure.
- Consider working with Emergency Medicine to include brochure for patients discharging with planned follow up in Ambulatory Care Clinic.
- Consider adjusting brochure to include information for other clinics which are at the Robert B Green Campus.
Care is managed and delivered in multiple opaque silos.

Data is available, but not in easily-accessible formats.

Reaching patients for feedback is burdensome with multiple barriers.

When approached, many key stakeholders very interested and excited to be involved.

Lessons Learned
Bill Bedwell, Executive Director Reimbursement Treasury Manager
Frank Borland, Executive Director Patient Access/Admissions
Dr. Lucy Leykum, Division Chief, General and Hospital Medicine
Dr. Rosemarie Ramos, Emergency Medicine Department University Hospital
Cynthia Saunders, NP
Melissa Villanueva, NP
Patricia Galindo, Patient Navigator Ambulatory Care Coordination
Debra Contreras Patient Navigator Ambulatory Care Coordination
Cindy Gamboa, Patient Navigator Community Medicine Associates Robert B. Green Campus
Joan Autry, Executive Director Business Services Ambulatory
Mario Noli Legarde, Executive Director Patient Care Services
Ashley Britsch, RN (Charge RN 12MSU)
All unit secretaries, charge nurses and bedside nurses on 9Rio, 7Horizon, and 12MSU/MSE

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