Post-Discharge Follow-Up P&P Guide – Use the below as a guide for conducting post-discharge follow-up and customize to your practice and EHR. Italicized, highlighted text provides additional guidance and needs to be deleted once read or acted upon. The AHRQ Re-Engineered Discharge (RED) Toolkit can be helpful, but note that some of the material is specific to hospital discharge staff http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html

POLICY

Our policy is to track and support patients after discharge from an inpatient admission. Patients are at risk for adverse events and possible readmissions during the post-discharge period. Additionally, it can be a fearful and anxiety-provoking time for patient, family and caregivers alike. We endeavor to reduce the risk of adverse events and readmission by providing access and support that will also reduce fear and anxiety. Our primary goals are to:

- Reconcile medications from pre-and post-hospital stay
- Facilitate access to prescribed medications
- Educate patient on conditions and necessary follow-up
- Reduce the risk of readmission to hospital
- Coordinate additional follow-up and/or specialty care

We monitor patient discharges from the several hospitals – see Table 1. We contact patients within 72 – 96\textsuperscript{1} hours of discharge and schedule patients triaged for a follow-up visit within seven to 14 days of date of discharge.

PROCEDURES

Identification and tracking of discharged patients

For each of the hospitals where your patients are admitted (within a reasonable geographic spread), identify who obtains the list of discharged patients (the role not the name of the individual), how frequently the list is “pulled”, and how frequently.

Table 1 – Hospital and method of identification of admitted/discharged patients

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Role</th>
<th>Frequency</th>
<th>Method/Workflow</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC</td>
<td>Medical Records</td>
<td>Every AM</td>
<td>Access XYZ HIE and select “Patients Discharged”; use filter “Within Past 7 Days”</td>
</tr>
<tr>
<td>XYZ</td>
<td>Front Office Clerk</td>
<td>Every PM</td>
<td>Put list of faxed patients in care coordinator Inbox</td>
</tr>
</tbody>
</table>

\textsuperscript{1} Literature supports calls within 48 – 72 hours, but that may be difficult or impossible to accomplish. Reduction of 30-Day Preventable Pediatric Readmission Rates With Postdischarge Phone Calls Utilizing a Patient- and Family-Centered Care Approach J Pediatr Health Care. 2015;29(6):492-500.
Given that patients may be discharged from multiple hospitals, enter how you will track all discharged patients to know their disposition, including risk status: unable to reach after x calls (letter sent), scheduled for visit, visit not needed, and declines visit. Will you do this by Excel spreadsheet, through the EHR or something else?

Maximized discharge planning

For each of the hospitals listed in the policy section, identify any known details about the discharge planning process. Hopefully, the practice has partnered with the hospital discharge planners to ensure that patients leave the hospital with a scheduled appointment with your practice – samples below.

ABC Hospital – discharge planner’s extension at hospital is 3217. Discharge planner has agreed to call back line at time of discharge for expedited scheduling for post-discharge follow-up visit (PDFU). Discharge planner may also contact care coordinator for warm handoff of patients in need of close monitoring and follow-up.

XYZ Hospital – discharge planners state that they do not have time to schedule patient prior to discharge but have agreed to include practice business card in discharge paperwork with instructions to patient to call as soon as possible to schedule appointment.

Risk stratification for discharged patients

Insert your definition of patients at high risk for adverse events or readmission. Use an established risk assessment tool or develop your own criteria. Include if patients need a call only (low risk), visit within seven days (high risk) or visit within 14 days (medium risk)

8P risk assessment

LACE Index Scoring Tool – Google it. It’s a Word document

The WA State Hospital Association has some good risk assessment tools

Patient factors that increase risk of adverse events or readmission include but are not limited to:
• Psychiatric and behavioral health issues, including those with substance abuse
• Sixty-five and older and on Medicare
• Cognitive impairment or intellectual disability (or other barriers to learning)
• Food/shelter insecurity
• High-risk medications (e.g., steroids and narcotics)
• Clinical conditions (e.g., heart failure, renal disease, cancer, anemia and weight loss)
• Length of hospital stay

Contact with patients to schedule PDFU visit

Outline your procedures for contacting patients, including how many efforts will be made to reach patients to schedule follow-up visits. Consider using a flow diagram – see example below.

Using the patient lists noted in Table 1 above, the care coordinator(s) will contact patients by phone call within 72 – 96 hours of discharge to schedule a PDFU visit, if indicated.

Figure 1 – Post-Discharge Call Process

CC calls patient within 72-96 hours of DC

# correct?

YES

Make note in registration and send standard letter

NO

Document why not indicated in EHR; route to PCP.

Able to reach with 3 tries?

YES

PDFU visit indicated?

YES

Schedule within 7 days of DC

NO

NO

Schedule within 14 days of DC

CC – care coordinator
DC – discharge
PDFU – post-discharge follow-up

Post-discharge call

*Insert scripting for the post-discharge call, including documentation thereof in the EHR (ideally should have template). Sample call documentation form to consider for template may be found here:* [http://www.ahrq.gov/sites/default/files/publications/files/postdiscalldoc.pdf](http://www.ahrq.gov/sites/default/files/publications/files/postdiscalldoc.pdf)

1. Assess health status (ask patient about reason for admission, new diagnoses/findings, stable?):
2. Any wounds that need to be dressed or checked:
3. The patient is scheduled for the following tests and appointments: [list all]
4. Barriers to keeping those appointments include\(^3\): [list all]
5. Patient question “Are you willing and able to keep your appointments, including the one at our office?”\(^3\):
6. Instructions on whom to contact if problems arise\(^3\):
7. How safe does patient feel; do they feel they are at risk for a fall?
8. Questions the patient has:
9. Patient goals and treatment preferences\(^2\):
10. “Tell me the medications you’re taking” ([consider asking patient to gather meds at start of call; reconcile with what’s in the EHR – include any issues with taking as directed or obtaining refills]):
11. Receiving or need any home services?:
12. Need community resources?:
13. Ensure patient has adequate food, shelter and heat:
14. Verify and document patient understanding: ([Use teach back for all patients, even for those who you think understand (quick video demonstrating teach back)](http://www.nchealthliteracy.org/teachingaids.html)

**PDFU Measures**

*List all metrics associated with PDFU.*

Percentage of patients called within 72-96 hours

Percentage of PDFU patients scheduled within 14 days

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The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

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