CONNECTING SOUTH WEST ONTARIO

Analysis and Research: Increasing physician follow-up for acute care patients within seven days of discharge

Evaluating benefits is an important component of the connecting South West Ontario (cSWO) Program that helps to support and demonstrate the realization of health system benefits through the adoption of electronic health records (EHRs). By pursuing the measurement of organizational value (improvements in the efficiency of care delivery such as time-savings and redirected resources) and clinical value (patients undergo fewer unnecessary tests, patients have improved access to care), patients ultimately benefit from higher quality, better informed clinical decision-making.

The cSWO Analysis and Research program uses a research-based approach to identify areas of clinical best practice that are affected by the use of EHRs, and works collaboratively with clinicians to understand the value of EHRs. This formative evaluation process informs change management and adoption, and enables clinicians to use EHRs more effectively. This research does not include the use of any personal health information.

This document is one in a series of case studies which describe the clinical value of EHRs in different clinical settings and contexts, particularly with respect to clinical best practices. The work of the cSWO Analysis and Research program is ongoing; depending on the circumstance, these cases occasionally raise questions for further investigation, and clinicians are invited to participate in analysis and research to continue to develop these answers.

Value statement

The cSWO Regional Clinical Viewer, ClinicalConnect™, has enabled the Smithville Family Health Team (FHT) to increase the percentage of patients who receive a follow-up appointment within seven days of being discharged from hospital. Post-discharge follow-ups are known to result in fewer subsequent Emergency Department (ED) visits, lower readmission rates, and increased quality care for patients.

Value of receiving a physician follow-up appointment post-acute care discharge

Several chronic conditions, including Chronic Obstructive Pulmonary Disease (COPD), stroke, cardiac conditions, and diabetes are often targeted for measurement due to their association with readmission into hospital[1]. One Quality Improvement Indicator (QIP) used by several FHTs in the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) is patient follow-up by a primary care practitioner within seven days of discharge from hospital. Follow-up appointments are an important practice in reducing readmission into hospital. A retrospective study of 62,745 patients admitted to hospital for COPD found that patients, who had a follow-up appointment with a physician, had fewer ED visits and lower readmission rates compared to patients who did not receive a follow-up appointment[2]. The Association of Family Health Teams in Ontario states that follow-up by a primary care physician within seven days of discharge is associated with 68 fewer readmissions per 1,000 patients[3].

These studies communicate the need for tactics that increase the percentage of acute care patients receiving timely follow-up appointments with a primary care physician post-discharge. The ability to access patient discharge lists and details about the recent hospital visits through ClinicalConnect facilitates appointment scheduling, ultimately increasing timely follow-ups.

EHR usage for seven-day post-discharge follow ups

The Smithville FHT in Smithville, Ontario consists of physicians, inter-disciplinary health professionals, and support staff who provide patient-centered care in the Township of West Lincoln. ClinicalConnect has been utilized within the Smithville FHT to facilitate efficient information sharing between hospitals and primary care providers, and to increase the percentage of acute care patients who receive a follow-up meeting with a primary care provider within seven days of discharge.

The team at Smithville checks the ClinicalConnect patient discharge lists daily and books follow-up appointments with all discharged patients (excluding maternity patients) to ensure these patients are receiving a follow-up appointment during the recommended seven day window. Although the QIP recommends that patients with specific conditions should receive a seven day follow-up appointment, Smithville exceeds this performance indicator by targeting all patients for a follow-up, regardless of condition. Access to

ClinicalConnect has allowed the team to achieve a follow-up rate of 73 per cent, 26 per cent higher than the provincial rate of 47 per cent[4]. The Smithville FHT has shared their process with other FHTs in the LHIN, which has resulted in an overall increase in the HNHB LHIN follow-up rate to 48 per cent, again exceeding the provincial rate4. ClinicalConnect provides fast access to recent hospital admission details and immediate access to reports, which the Smithville FHT has found particularly helpful.

Smithville credits the success of increased patient follow-up via ClinicalConnect to several factors, including physician compliance throughout the process, dedicated administrators who book patients' appointments, and one designated person responsible for tracking patient discharges[5].

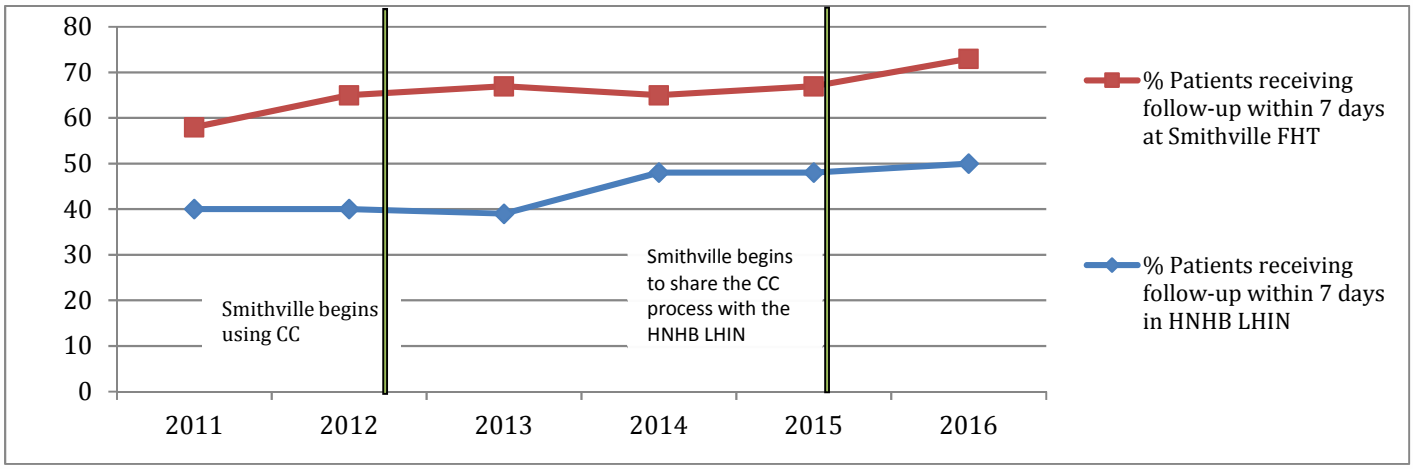

Figure 1 – Percentage of patients receiving a follow-up appointment with a primary care clinician within seven days post-acute discharge by fiscal year

Testimonial

"I have found ClinicalConnect to be the most important tool in managing our post discharge program at the Smithville FHT. I am able to easily access our discharge list electronically each morning. This allows me to identify patients who have been discharged in the last 1, 3, 7 and 14 days. We aim to identify our discharged patients in a timely fashion in order to arrange a post discharge appointment with their family physician or nurse practitioner within 7 days. Our ultimate goal is to prevent readmission to the hospital. ClinicalConnect even allows me to see our patient's admission diagnosis so that I am able to better facilitate the appropriate care. For example, we recently had a patient that was discharged because of congestive heart failure and since ClinicalConnect allowed me to see the discharge diagnosis I was able to facilitate an appointment with both the family physician and our nurse educator who specializes in the care of our heart failure patients. The system is user friendly and has been an important tool in enhancing the quality of care we provide as we can access important patient information that is helpful in our post discharge planning."

Michelle Webb, Nurse Educator, Smithville Medical Centre FHT

Questions

Authored by Wanda Hemsworth, Benefits Realization Lead, and Beth Murray, Benefits Realization Analyst, cSWO Change Management and Adoption Delivery Partner, HITS eHealth Office at Hamilton Health Sciences. For questions, comments, or to participate in cSWO's Analysis and Research program, please contact: cSWOresearch@lhsc.on.ca.

Sources

1. Grunier, A et al., (2011). Unplanned readmissions after hospital discharge among patients identified as being at high risk for readmission using a validated predictive algorithm.*OpenMedicine,* 5(2), E1022-E111
2. Shama, G., Kuo, Y., Freeman, J. (2010). Outpatient follow-up visit and 30-day emergency department visit and readmission in patients hospitalized for chronic obstructive pulmonary disease. *Arch Intern Med,* 170(18):1664-1670
3. AFHTO. (2017). A better way to track follow-up after hospitalization. Retrieved from: http://www.afhto.ca/measurement/a-better-way-to-track-follow-up-after-hospitalization-2/
4. Hamilton Niagara Haldimand Brant Local Health Integration Network (2017). *Ministry LHIN performance indicators May 2017.* Retrieved from: http://www.hnhblhin.on.ca/accountability/performance.aspx
5. Health Quality Ontario. (2016). Excellent Care for All Quality Improvement Plans (QIP): Progress Report for 2016/17 QIP. Retrieved from: https://qipnavigator.hqontario.ca/Resources/PostedQIPs.aspx

Published: July, 2017
Revised: August, 2018

Funded by eHealth Ontario