Hospital Discharge Follow Up Process

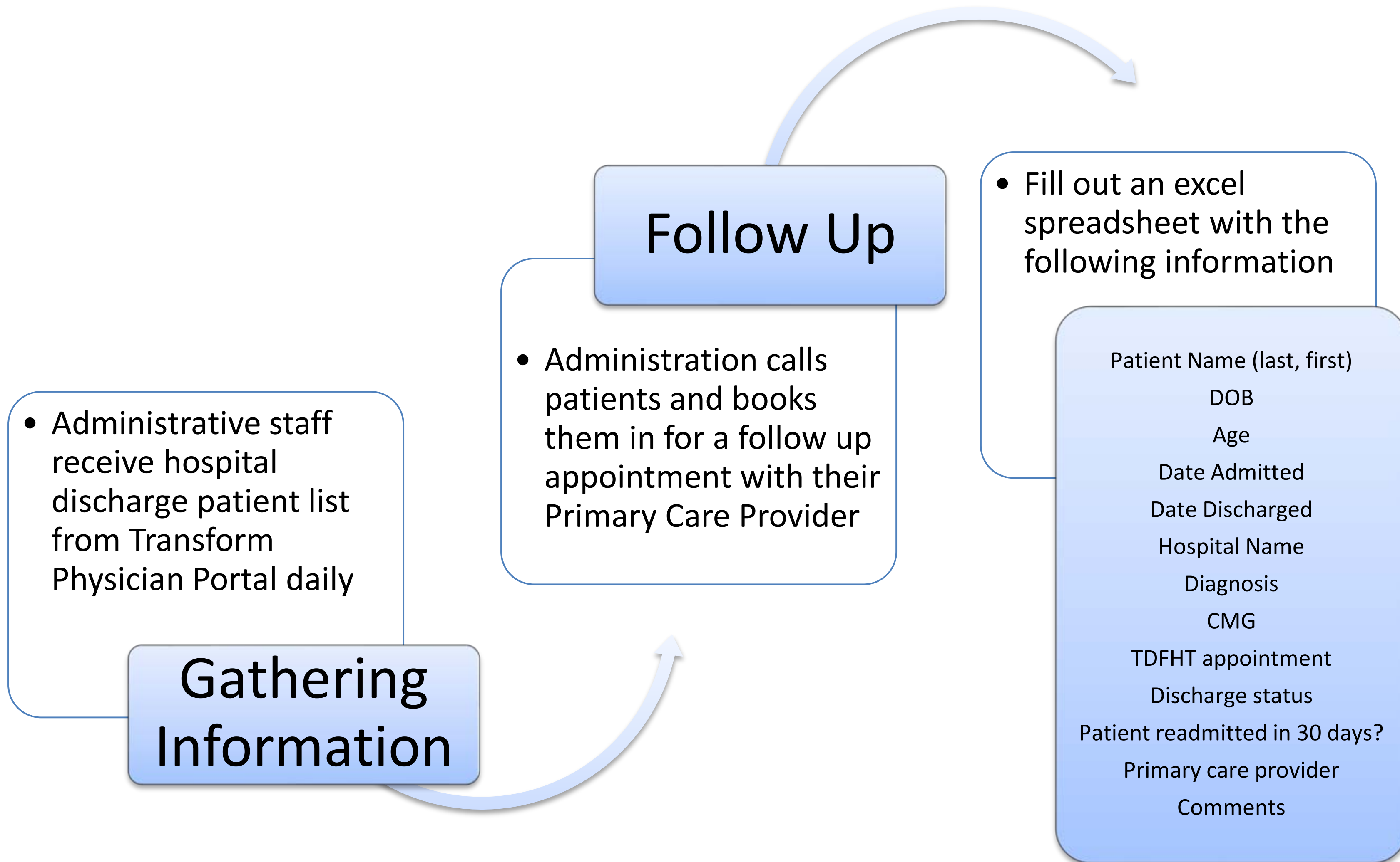
Identified barriers/gaps found because of current role

- Patients identified after a hospital visit felt lost post hospital discharge, not sure who to call, multiple services in home and unsure who is who
- Time delay between patients requiring case management and identification
- Lack of health teaching post hospital discharge
- Acute conditions required intense ~<1 month case management
- Chronic conditions required intense care coordination and case management ~>1 month and ongoing

TDFHT demographics

# Patients	15,000
# Primary Care Providers	6 physicians, 2 Nurse Practitioners
# Nurses	5 RPNs, 3 RN's
# IHP's	1 Dietitian, 2 social workers, 1 RT, 1 Diabetes educator, 1 Chiropodist
Location	Rural
Patient Demographic Area	Borders between Chatham-Kent and Windsor-Essex

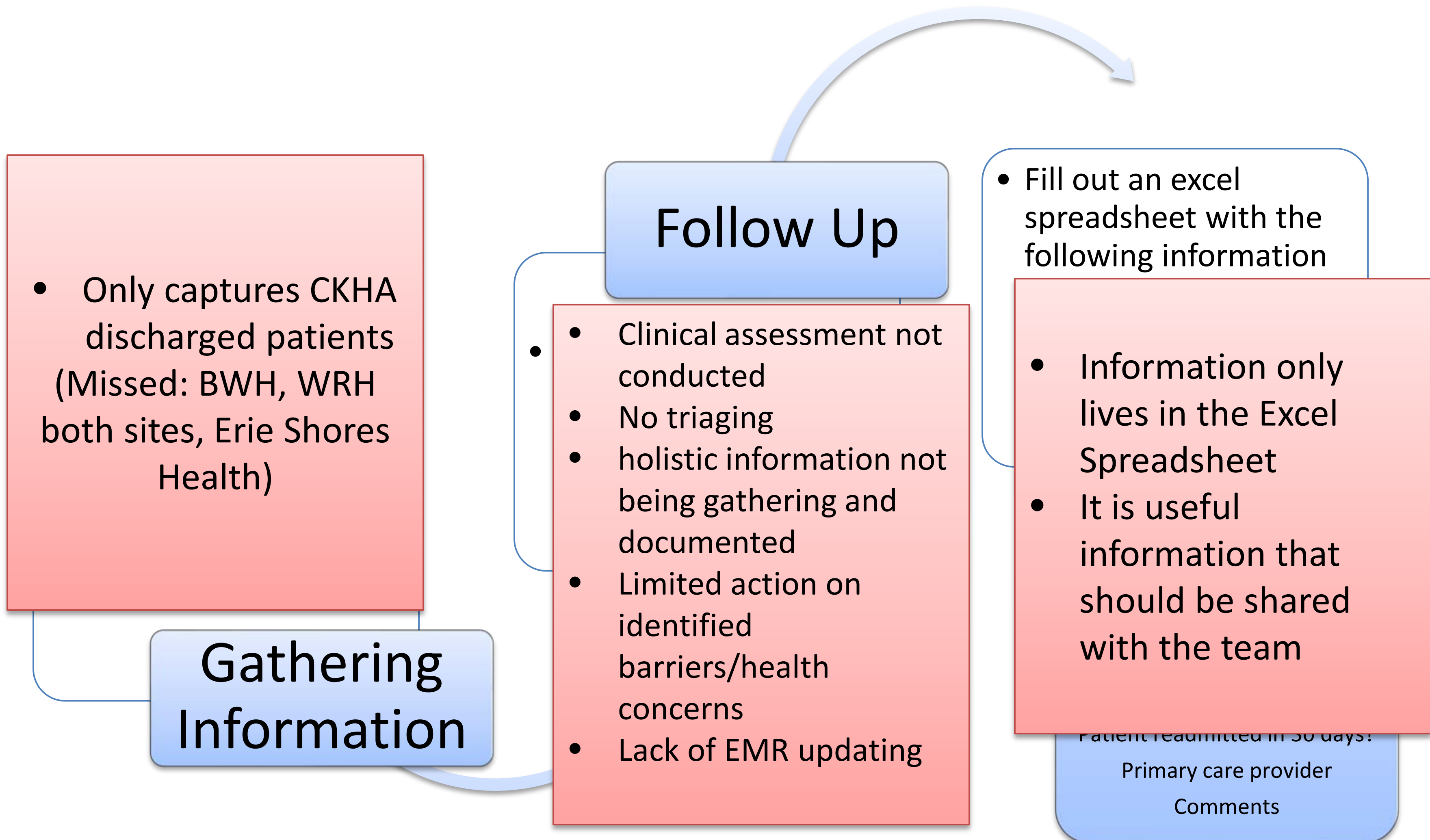
Old Hospital Discharge Process



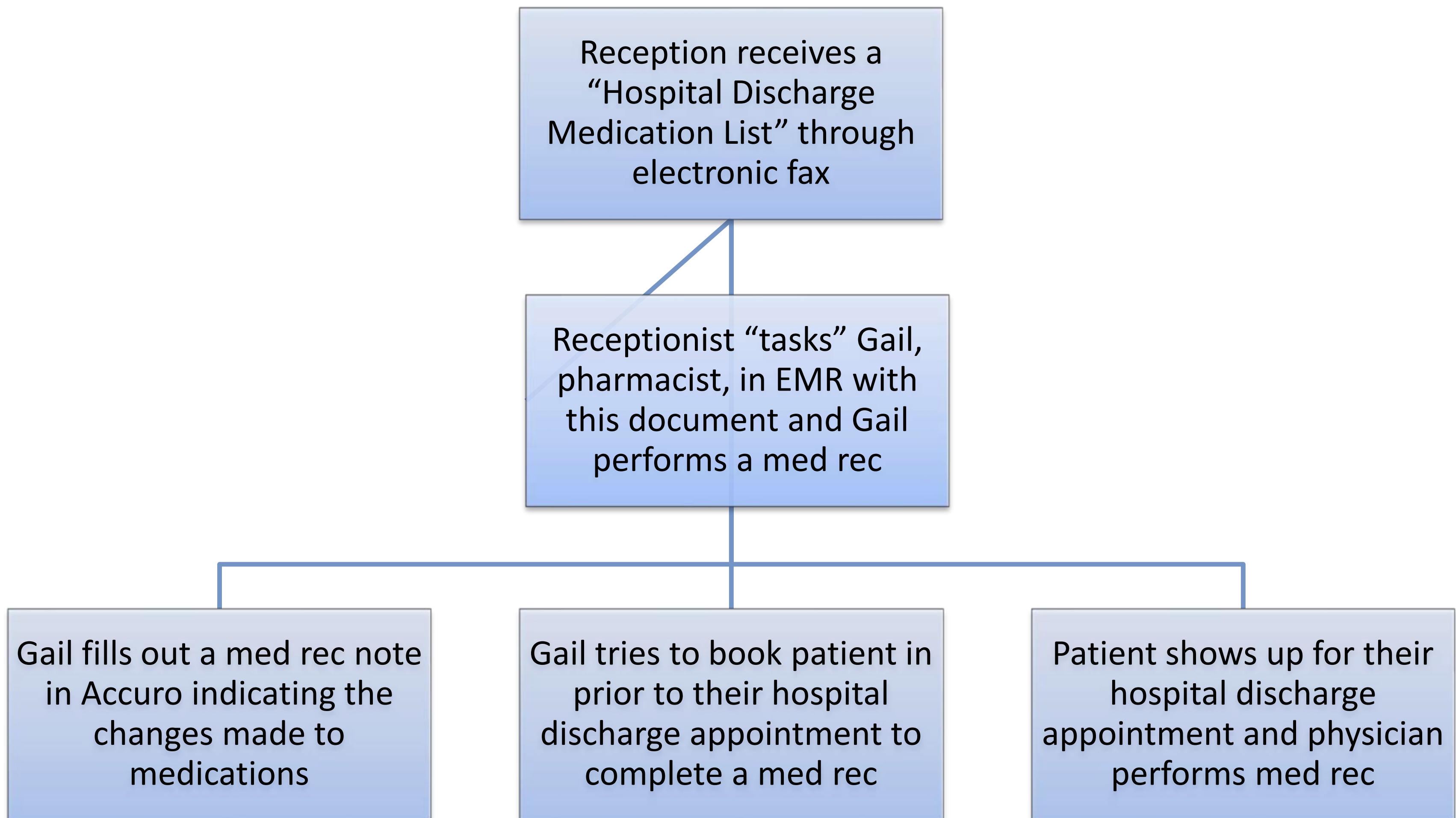
Tilbury District
FAMILY HEALTH TEAM
22 Mill Street West PO Box 760, Tilbury, ON, N0P 2L0
Phone.519.682.2307 Fax.519.682.9979

Barriers & Gaps

Hospital Discharge Process

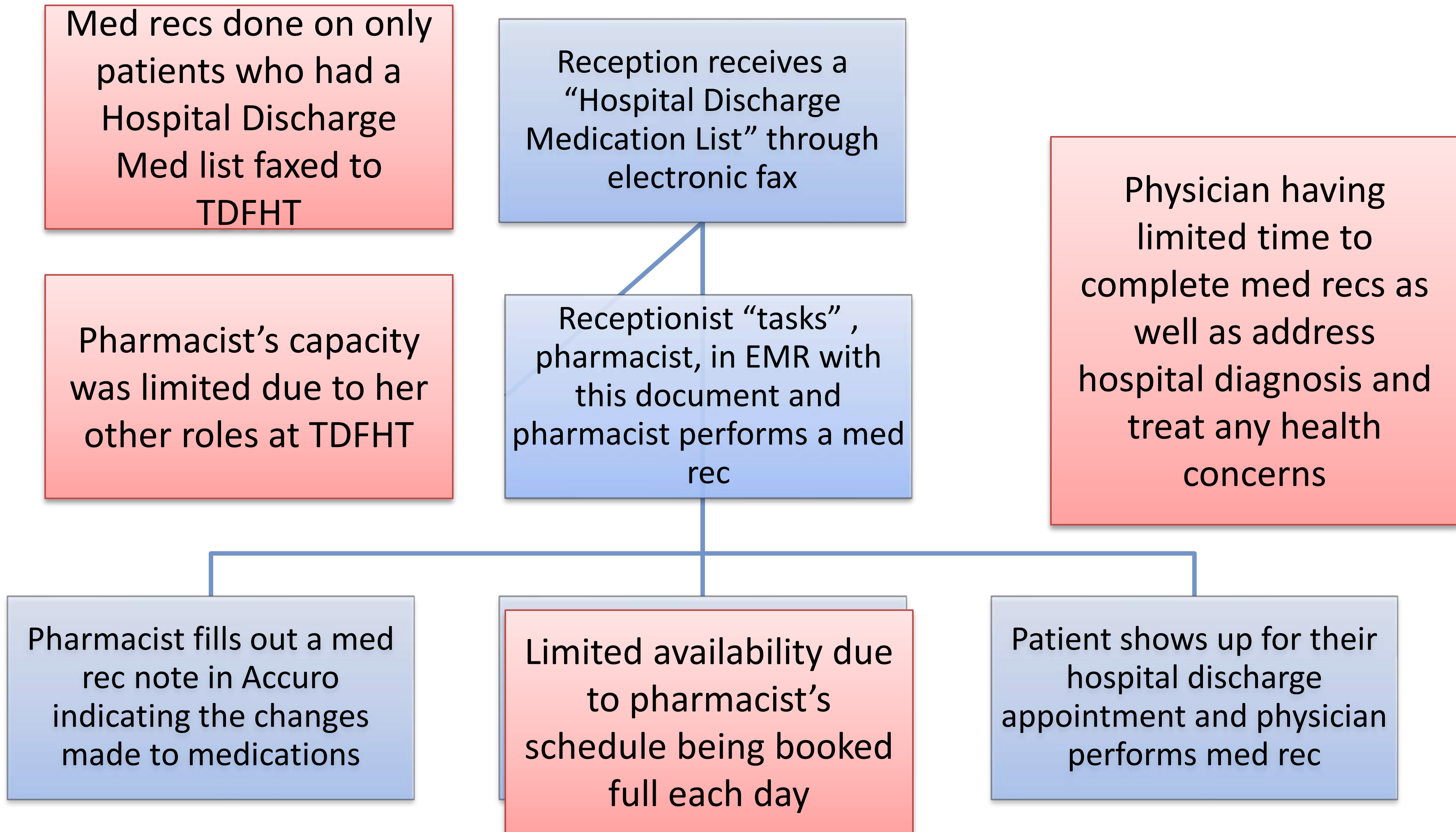


Old Medication Reconciliation Process



Barriers & Gaps

Hospital Discharge Medication Reconciliation



Old hosp dc data

Date	Discharges	7 Day Follow-up	7 Day Follow-up Rate	30 Day Follow-up	30 Day Follow-up Rate
Jul-16	48	16	33%	35	73%
Aug-16	62	18	29%	41	66%
Sep-16	77	29	38%	51	66%
Oct-16	80	18	23%	55	69%
Nov-16	70	19	27%	47	67%
Dec-16	84	26	31%	54	64%
Jan-17	66	18	27%	46	70%
Feb-17	73	21	29%	46	63%
Mar-17	76	24	32%	51	67%
Apr-17	93	29	31%	69	74%
May-17	67	25	37%	47	70%

Process Planning Preparation

- Took patient journey through TDFHT
- Took paper trail through TDFHT
- Collaboration with other FHTs

Hospital Discharge Process Creation

Formed a TDFHT Hospital Discharge Process working group:
1 physician lead
1 admin lead,
1 pharmacist,
1 RPN
1RN/Health Link case manager

Collaborated with our Accuro IT member to create our forms and queries we required

Met monthly with our working group to discuss barriers each faced with hospital discharges and created solutions

3 working group meetings
3 Accuro IT meetings

Go Live Day

June 21 2017

Hospital Discharge Process Map

Discharged patient identification

Physician Portal

Accuro EMR Query

"In-Patient Enotification

Patients added to Excel Spreadsheet

"TDFHT Hospital Discharge Tracking sheet"

All newly added patients indicated in green

RN performs brief chart review "History and Physical" "Consultation note", "Hospital Discharge Summary"

Physician Tasked to update Diagnosis list with new/outstanding diagnosis

Surgical & Procedures list updated

RN calls patient

Patient does NOT answer

Voice mail left and indicated in EMR

Patient indicated in yellow in Excel Spreadsheet

2 voice mail attempts made post hospital discharge

Patient shows up for an appointment

PCP reviews Hospital Discharge Follow up Form

Patient answers and RN assesses the following and documents in the "Hospital Discharge Follow Up" Form

Admission and Discharge Date

Admitting Diagnosis

Is this a readmission in the past 30 days?

Yes

CMG

LHIN (CCAC) Services

EMR updated with current LHIN supports including Care coordinator name and contact

Discharge Disposition

Follow up appointments (Specialists, IHPs, Community)

Name of Specialist

Date of appointment

Does patient have specialist contact number?

TDFHT IHPs Involved in patients care

IHPs Tasked with attached Hospital Discharge Follow up Form for their review

Risk for Malnutrition (Canadian Nutrition Screening Tool)

If screener score 2/2, Task Dietitian that patient is at risk for malnutrition

Patient booked in for follow up with PCP and IHP same day if available

Transportation

Patient has transportation/Access Barriers

Consider booking Initial Health Link Home Visit

Patient's transportation status updated in EMR

Current Patient Situation (Nursing Assessment)

Patient experiencing Health Concerns

Patient booked in for same day/ next day appointment

No current health concerns

Health Teaching

Extension provided as a contact resource until follow up appointment

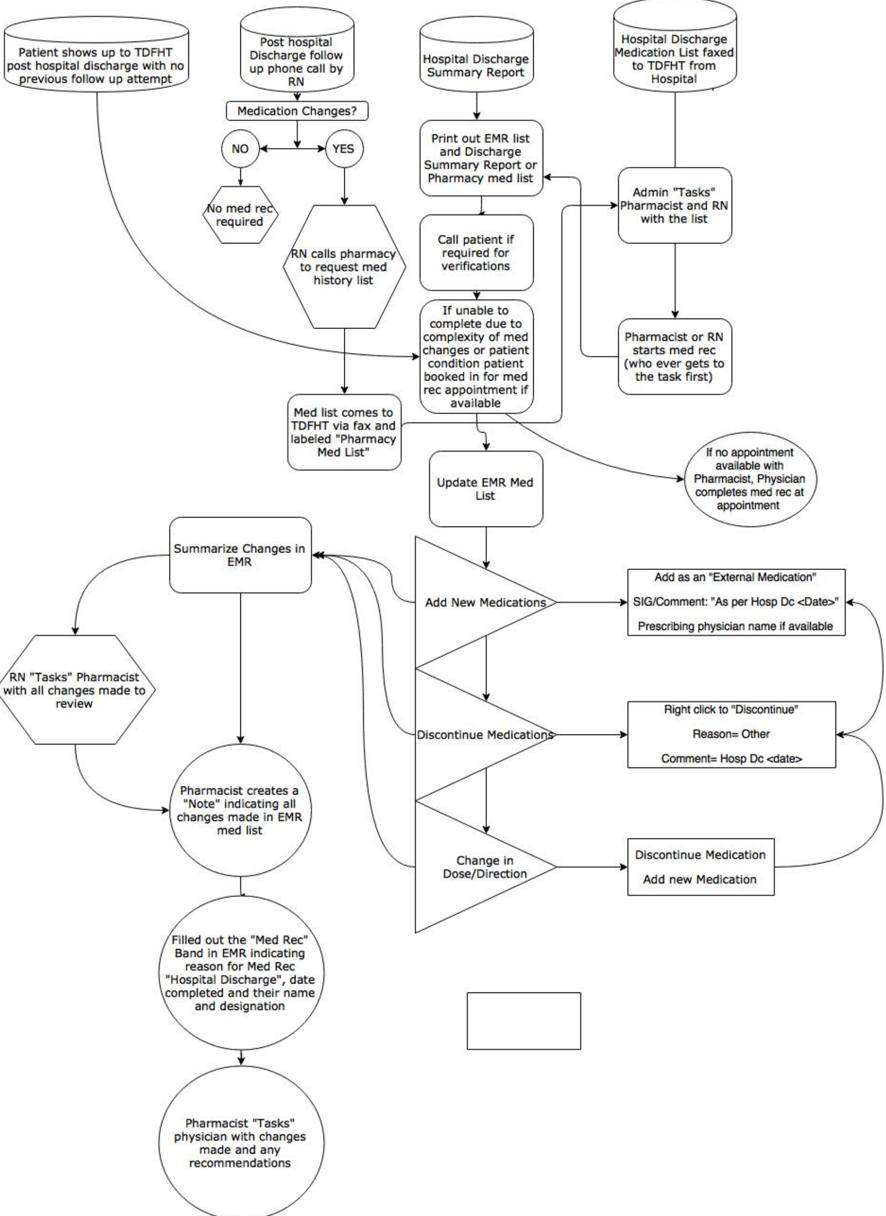
HARP score

If >17 determine eligibility for Health Link Case Management

Medication Changes?

Medication Reconciliation Process

New Medication Reconciliation Process



Hospital Discharge Follow Up Assessment Form

Hospital Discharge Follow-up

Form Date
Feb 1, 2018
Form Completed by
Diana Hegedus

Admission Date: MM/DD/YYYY
Discharge Date: MM/DD/YYYY
Reason for Visit

☐ **This was a 30-day readmission**

Hospital
Chatham Kent Health Alliance

Discharge Disposition
Home

Follow-up Required? ☐ **Yes** ☐ **No**

CMG
- ☐ Cardiac
- ☐ CHF
- ☐ COPD
- ☐ Diabetes
- ☐ GI
- ☐ Mental Health
- ☐ OB
- ☐ Pneumonia
- ☐ Stroke
- ☐ Surgery

LHIN Services
- ☐ Nursing
- ☐ PSW
- ☐ PCCT
- ☐ PT
- ☐ OT
- ☐ Clinic
- ☐ R R Nurse
- ☐ Telehome
- ☐ None

Primary Care Provider
Dr. Jean-Marc Beausol

Patient Name
Brice2 (Bricey) Test

Patient Age
55 Yr

Follow-Up Appointments
- MM/DD/YYYY
- MM/DD/YYYY
- MM/DD/YYYY
- MM/DD/YYYY

TDFHT Follow-up Appointment Booked

Program Involvement
- ☐ Diabetes Education
- ☐ Foot Care
- ☐ Health Link
- ☐ Lung Health
- ☐ Mental Health
- ☐ Nutrition
- ☐ Smoking Cessation

Patient's Situation

Health teaching required? ○ Yes ○ No

Diagnosis list updated? ○ Yes ○ No

Surgery/Procedure list updated? ○ Yes ○ No

Lifestyles list updated? ○ Yes ○ No

Primary Care Access barriers? ○ Yes ○ No

Medication Changes? ○ Yes ○ No

Med Rec task sent to Pharmacist? ○ Yes ○ No

HARP Score ☐ Readmission Risk Level

Patient is Health Link eligible? ○ Yes ○ No

At risk for malnutrition? ○ Yes ○ No

Referral to dietitian? ○ Yes ○ No ○ Refused

Outcome
- ☐ **Nurse extension given (If Applicable)**
- ☐ **Patient advised to bring all medications to follow-up appointment with primary care provider**
- ☐ **Patient aware to attend urgent care if having any health concerns prior to scheduled appointment**
- ☐ **Patient aware to return to ER if requiring immediate medical attention**

Updating the EMR

Lifestyle

2018-Feb-03 Health Link Coordinated Care Plan [***Last Revision: Diana Hegedus RN***]

2018-Feb-01 Income [***ODSP: worker Candy Cane 999-999-9999***]

2018-Feb-01 Food Security [***Meals on Wheels***]

2018-Feb-01 Health Link Coordinated Care Plan [***Created: Diana Hegedus RN***]

2018-Feb-01 Family Member [***wife-Marie SDM 519-999-9999***]

2018-Feb-01 Supports [***LHIN care coordinator: Jane Doe 999-999-9999 ext 0000***]

2018-Feb-01 Supports [***Visiting Nurse: Bayshore 1x/wk***]

Marital Status [***Married***]

Smoking Status [***Ex-Smoker: quit after smoking cessation NRT***]

Pets in Home [***dog***]

Housing [***lives in a one-storey home***]

Education [***finished grade 10***]

Religion [***Catholic: goes to St Michaels church every Sunday***]

Retired [***former line worker at Chrysler***]

Language [***English***]

Self Monitoring routines [***checked BP and weight daily***]

Assitive Devices [***Walker***]

Transportation [***Relies on others: CHAPS 519-999-9999***]

Social Support Network [***plays cards with friends weekly***]

Hobbies [***Watching baseball, hockey***]

Discharge to Follow Up

Patient provided with the following:

- Health teaching
- Healthcare navigation
- TDFHT program/service navigation and referral
- Ensure accessibility/transportation
- Nurse contact during business hours
- EMR update
- Medication reconciliation
- Malnutrition screener
- Urgent care hours and utilization reviewed
- Reminder to bring medications to appointment
- Collaboration among their TDFHT circle of care and sometimes LHIN home care
- Introduction to Health Links model of care
- Immediate needs met
- A mode of follow up regardless if they are able to see their PCP
- Coordinate all their TDFHT appointments to accommodate accessibility, and effectiveness
- HARP tool to determine timely referral to Health Link case manager

Follow-Up Appointment Day

Team provided with the following:

- Overview of patient's current state since being discharged home
- Medication list up to date
- Awareness of current community services that are part of the patient's circle of care
- A more personal view of the patient
- Updated diagnostic/ problem list
- Surgery/Procedure list up to date
- Dates of follow up appointments for referrals made in acute care
- One page focused summary of the patient's admission
- Ability to focus follow up appointments more on recommendations and patient's requests.
- Reduced amount of time searching for pertinent information

Routes of Health Link Referrals

- Physician referral
- Hospital Discharge Follow Up Process
- EMR Queries for acute care utilization

Health Link Intake Form

Intake Form

Patient Name	Age	Family Physician	Next Appointment	Address
Brice2 (Bricey) Test	55 Yr	Dr. Jean-Marc Beausoleil		ON, Canada

Contact

(H) (000) ___-____
(C) (519) 586-5___
(W) (000) ___-____
(E)

Date of Eligibility: 2018-Feb-01
Date of First Contact: MM/DD/YYYY
Eligibility Method: Physician Referral

- [ ] Lives Alone
- [ ] No / Limited Supports
- [ ] Cognitive Decline
- [ ] Medication Incompliance
- [ ] History of Falls within Last 3 Months

Number of Medications: 0
Number of Complex Conditions: 0
Number of Providers Actively Involved in Patient Care:
# of Office Visits in Last 6 Months:
HARP Score at Eligibility:

Priority Score: **0**

HRM In-Patient Discharges

HRM ED Discharges

History of Problems

2017-Mar-16 DIABETES MELLITUS

Active Medications

2017-Dec-22 SPIRIVA RESPIMAT 2.5 MCG INHAL 2 Puffs Once daily x 30 Day(s)
2017-Dec-22 SPIRIVA RESPIMAT 2.5 MCG INHAL 1 Puffs Once daily x 1 Day(s)
2017-Nov-28 Ramipril 10 mg Oral Capsule
2017-Nov-28 TYLENOL 500 MG TABLET
2017-Nov-28 Amoxicillin 500 mg Oral Capsule
2017-Nov-21 ASPIRIN 81 MG TABLET EC
2017-Nov-21 TECTA DR 40 MG TABLET 1 Tablet(s) Once daily x 1 Day(s)
2017-Nov-21 IMODIUM LIQUI-GELS 2 MG CAP 1 Capsule(s) Four times daily x 2 Day(s)
2017-Nov-21 ASPIRIN 81 MG TABLET EC
2017-Nov-13 DEXILANT DR 60 MG CAPSULE 1 Capsule(s) Once daily x 30 Day(s)
2017-Apr-28 OXYNEO 20 MG TABLET 1 Tablet(s) Two times daily x 30 Day(s)
2017-Apr-28 Atorvastatin Calcium 40 mg Oral Tablet 1 Tablet(s) Once daily x 1 Day(s)
2017-Jan-24 TYLENOL 325 MG CAPSULE 1 Capsule(s) Once daily x 1 Day(s)

Lifestyle

Health Link Coordinated Care Plan [***Last Revision: Diana Hegedus RN***]
Income [***ODSP: worker Candy Cane 999-999-9999***]
Food Security [***Meals on Wheels***]
Health Link Coordinated Care Plan [***Created: Diana Hegedus RN***]
Family Member [***wife- Marie SDM 519-999-9999***]
Supports [***LHIN care coordinator: Jane Doe 999-999-9999 ext 0000***]
Supports [***Visiting Nurse: Bayshore 1x/wk***]
Marital Status [***Married***]
Smoking Status [***Ex-Smoker: quit after smoking cessation NRT***]
Pets in Home [***dog***]
Housing [***lives in a one-storey home***]
Education [***finished grade 10***]
Religion [***Catholic: goes to St Michaels church every Sunday***]

Pre-populates into CCP

My Identifiers					
Given name: **Brice2 (Bricey)**	Preferred name:		Surname: **Test**		
Date of birth: **1962-Nov-02**	Gender: **F**		Preferred pronoun: **Mrs.**		
Address:					
City:		Province: **ON**	Postal code:		
Telephone number: **(000) -**	Alternate telephone number: **(519) 586-5**				
Health card number:	Issued by: **ON**		Ancestry/culture:		
Identify as First Nation, Métis, or Inuit? ◯ Yes ◯ No	If "yes," specify which nation:				
Preferred language: **English**	Communication accommodations:				

More About Me

Lifestyle

Health Link Coordinated Care Plan [*Last Revision: Diana Hegedus RN*]
Income [*ODSP: worker Candy Cane 999-999-9999*]
Food Security [*Meals on Wheels*]
Health Link Coordinated Care Plan [*Created: Diana Hegedus RN*]
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Transportation [*Relies on others: CHAPS 519-999-9999*]
Social Support Network [*plays cards with friends weekly*]
Hobbies [*Watching baseball, hockey*]

My Health

History of Problems

2017-Mar-16 DIABETES MELLITUS

Surgeries & Procedures

None Recorded

Preventative Care

None Recorded

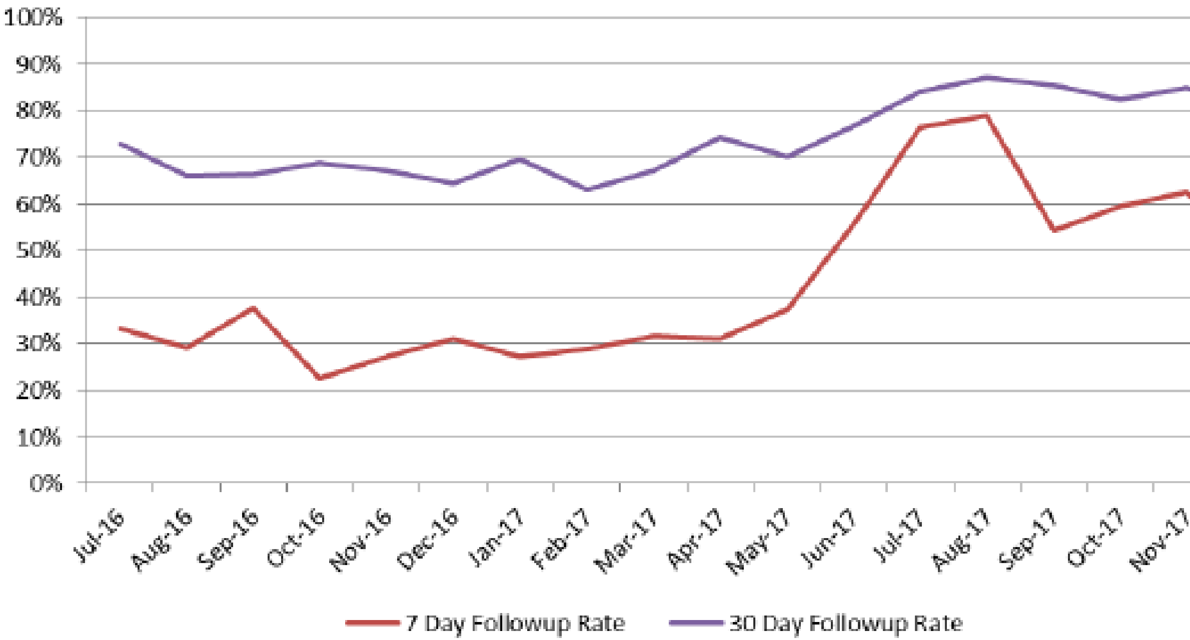
Preventative Care

FOBT [***Results - Negative***]
Mammogram [***Results - Normal***]

Utilizing RPNs

- RPNs on boarded with Hospital Discharge Process for new mothers and all post op patients
- Rationale- both processes are more streamlined and least time consuming

Improving



Ideas for sustainability

- RPN utilization in this hospital discharge follow up process
- Involving external resources in the medication reconciliation process

Hopes for the future

- Involving community pharmacists and external resources
- Acute care engagement
- Share our hospital discharge follow up process creation to others so they can implement a similar process that works for them