

# Follow-up After Hospitalization: Proposed definition and Suggestions for D2D 4.0

## Purpose for a follow-up indicator

Measuring follow-up after hospitalization is intended to help teams coordinate care for recently hospitalized patients to reduce their risk of “falling through the cracks” and going back to hospital.

## Background

Follow-up of patients by primary care providers after hospitalization is a valuable way to improve patient outcomes. However, the available indicator is currently too old and excludes too many important concepts (i.e. follow-up by non-physicians, follow-up by phone etc.) to be useful to support measurement and improvement by local primary care providers. This document describes an approach to measuring follow-up after hospitalization that reflects the contribution of the ENTIRE team to coordinating care in whatever way works best for patients. It also includes suggestions regarding inclusion of the indicator in D2D 4.0 based on the clinical consultation process.

## Proposed Indicator Definition

All hospitalized patients with in-person OR phone contact with ANY clinician within 7 days of discharge from hospital.

See appendix A for rationale for the definition.

## Suggestions regarding inclusion in D2D 4.0

The following suggestions emerged from extensive consultation with members and stakeholders (see Appendix B).

Use the proposed definition for D2D 4.0: Using the proposed definition will spread the story of how teams are finding ways to follow-up with recently hospitalized patients against all odds. Generating these data can also help build momentum to overcome the persistent technical barriers to measuring and improving coordination of care for recently hospitalized patients.

Improve access to timely hospital discharge data: Many teams have local solutions for getting hospitalization data for their patients. In addition, electronic tools such as Hospital Report Manager are being implemented to automatically share hospital data with primary care providers. Neither of these solutions is complete, with many stories of hospitalized patients falling through the cracks. Increased support and resources to ensure that ALL teams have timely, easy access to hospital discharge data is crucial to the success of measuring and improving coordination of care for recently hospitalized patients.

Start with a broad definition to create capacity for future refinements: It is likely that some patients have higher needs for coordination of care after hospitalization than others. And it is currently very difficult to get ANY timely data about hospitalizations, let alone sufficiently detailed descriptions to narrow the focus of the information to specific subsets of patients. Building relationships and IT bridges

with hospitals and other providers also involved in follow-up will make it more possible to refine the definition in future iterations of the indicator.

Provide EMR and workflow supports for data capture: Standardized EMR queries have already been developed by QIDS Specialists for 3 EMRs with work underway for others. Examples of electronic forms (such as EMR “stamps”), “fake” billing codes and other workflow suggestions are being compiled (see Appendix B). Ensuring teams have access to a menu of options will reduce the time and effort for clinicians to capture these data.

Encourage research partnerships to determine optimum approach for follow-up: There is no solid evidence about what kind of follow-up (eg phone, in-person) by whom (eg physician, IHP) for which patients (eg all, those with chronic conditions only) when (eg 7, 14, 30 days) has the most impact on patient outcomes. Researchers working with a subset of teams able to drill down into more detailed data could help providers better understand where and how to focus follow-up efforts.

## Appendix A: Rationale for the proposed definition

- Input to-date suggests that there is a solid consensus on the need to measure and improve follow-up after hospitalization ([see Appendix B: Input to-date](#)).
- There is also equally solid consensus that follow-up could and should be broader than an “in-person visit to a physician.”
- The current physician-billing-based indicator will paradoxically reflect WORSE performance where team-based follow-up is excellent (e.g. pharmacist phone calls for medication reconciliation), which is counter to the goals of teams and the MOHLTC.

### Additional benefits for increasing access to phone encounter data in EMRs:

- Phone encounter documentation is already a required and common component of EMR records and is in fact, a requirement of [CPSO](#).
- Access to phone encounter information will increase ability of teams to track the contribution of all team members to primary care, independent of the use of this data for this indicator.
- Data about phone encounters can support efforts to increase recognition of the value of this mode of primary care delivery in addition to “in person” visits as a billable service.

## Appendix B: Input to-date

### 1. D2D 2.0 (JUNE 2015)

**Preamble:** [7-day follow-up was included in D2D 2.0 as an exploratory](#) indicator to facilitate knowledge transfer and exchange, with the goal of informing a more appropriate definition of this indicator for subsequent iterations of D2D. This indicator was populated only by teams who are already tracking 7-day follow-up in a formal way, at the time of data submission to D2D 2.0.

**Results:** 64% of teams that submitted data reported a higher rate of follow-up after hospital discharge as compared to the Ministry data accessed through the HDB report. These data perhaps best illustrate the fundamental problem, that is, the current definition for this indicator is not representative of the work that is actually happening in the field of primary care. Notably, 28

teams report being able to get hospitalization data one way or another to measure and improve their local follow-up rate.

## 2. Clinical consultation

**Preamble:** Individual and group consultations with approx. 30 physicians to gather input on a revised definition for this indicator (JULY 2015 – JAN 2016)

### Summary of Input from one-on-one consultations:

- Solid consensus:
  - Include follow-up provided by any clinical member of the team
  - Include documented interaction of any kind (i.e. phone, in-person, home visit etc.)
- Semi-solid consensus:
  - Medication management seems to be most urgent issue requiring follow-up.
  - Retain 7 days as interval for measurement (no evidence of impact for any interval)
- Input but not consensus:
  - Consider only patients with a discharge summary received by primary care within 48 hours
  - Retain focus on patients with chronic conditions only
  - Not all patients need follow-up by primary care because some don't need it all and others are getting it from other providers or from the primary care provider while in hospital.

## 3. Membership-wide vote (NOVEMBER 2015)

- 85% of respondents agree D2D should include a measure of follow-up after hospitalization.
- There is virtually complete consensus that follow-up should include phone as well as in person (100%) and can be done by ANY clinician, not just a doctor (96%).
- Only 57% agree the measure should be based only on patients for whom timely discharge information was received
- Only 52% agree that the cut-off for follow-up should be 7 days, with some arguing for 48-72 hours and others for 30 days or no particular interval at all.

## 4. MOHLTC advice re: contract indicators (JANUARY 2016):

**Preamble:** AFHTO discussed this indicator with MOHLTC in the context of proposing indicators for inclusion in the new FHT contract.

### Input:

- MOHLTC recognized the risk of persisting with the admin-based indicator as outlined above. They also agreed that the existing indicator would continue to be readily available to MOHLTC and any other users as it is generated from administrative data. They agreed that the proposed definition based on EMR data about phone encounters would better serve the goal of team-based measurement and improvement of performance in the area of follow-up.
- Teams may wish to consider asking a standardized question in their patient experience survey to obtain data for an internationally comparable measure. See [Primary Care Performance Measurement Framework \(PCPMF\) pg 114/115, Follow-up arrangements after hospital discharge](#)

## Appendix C: Enablers for Implementation:

### Standard EMR queries

- Extracting data from the EMR for phone encounters for all types of clinicians is absolutely necessary to proceed with the proposed definition. It is already possible to extract data for in person visits so the most pressing focus is on extending that capability to phone visits.
- Standard EMR queries (and related tools) have been developed for 3 EMRs (Telus PS, Accuro, Nightingale) covering 78% of AFHTO members. Work is underway with an additional 2 EMRs to bring total coverage to 93% of AFHTO members.

### Workflow

Examples of changes in workflow include the following:

- adding a shadow billing code to the phone-call documentation process
- adding a tick box to indicate the nature of encounter when doing phone documentation
- getting all physicians to agree on the text to include in phone-call documentation
- installing (and training clinicians on) a “form” to be used for phone-call documentation

### Increased Access to Hospital Discharge Data

About 60% of teams contributing data to D2D 2.0 indicated that there is automated integration of hospital data with their EMR via tools such as, HRM, SPIRE, TDIS, POI etc. 28 teams have their own local processes for accessing hospital data, as evidenced through data submitted for the *exploratory indicator* in D2D 2.0 ([click here to read their stories](#)). QIDSS have been sharing strategies to access hospital data (inpatient and ED visit data) between teams. Other examples of how teams are accessing hospital discharge data and initiatives aimed at improving access to hospital discharge data include the following:

- [A better flavour for 7-day follow-up](#)
- [Data for quality improvement: working with our hospital partner on QIP access/integration goals.](#)

### Increased accountability for hospital information sharing

The South West LHIN has implemented a [publicly-reported measure](#) of timely discharge information sharing (see Figure below). This work could be leveraged to begin holding hospitals accountable for timely information flow.

