The Post-Hospital Follow-Up Visit:
A Physician Checklist to Reduce Readmissions

California HealthCare Foundation

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Introduction

Primary care practices are uniquely positioned to intervene with their recently discharged patients to prevent unnecessary hospital readmissions. The post-hospital follow-up visit presents a critical opportunity to address the conditions that precipitated the hospitalization and to prepare the patient and family caregiver for self-care activities.

Despite the importance of the visit during this vulnerable post-discharge time period, little specific attention has been paid to it in the literature, and there has not been well-established consensus on best practices for this type of encounter. To begin filling the gap, this issue brief presents a proposed checklist for post-hospital follow-up visits for primary care physicians. It draws from diverse sources including published protocols found in the scientific literature and unpublished approaches identified via the Internet. Leading textbooks of family medicine, geriatric medicine, and internal medicine were reviewed and leaders of the American Board of Family Medicine and the American Board of Internal Medicine were consulted. In addition, thought leaders with expertise in health care delivery were interviewed and asked to describe innovations implemented in their organizations.

New Emphasis on Post-Hospital Visits

Recent national policy developments aimed at aligning financial incentives to reduce preventable hospital readmissions have prompted greater focus on post-hospital ambulatory visits. For example, the newly enacted health reform law promotes bundled payments approaches, accountable care organizations, and study of a new payment code for services furnished by an appropriate physician who sees an individual within the first week after discharge from a hospital.[1] The success of bundled payment and accountable care organization pilot and demonstration programs hinges, in part, on ensuring timely and effective post-hospital follow-up visits. Further, patient-centered medical homes are expected to play a greater role in coordination of care in exchange for added monthly per-patient payments.

In addition, the Transitions of Care Consensus Policy Statement, jointly endorsed by six physician professional societies, recommends principles and standards that address the physician's accountability in managing care transitions between the inpatient and outpatient settings.[2]

These initiatives are in part predicated on the assumption that primary care practices are both well positioned and well prepared to intervene in the cycle of hospital readmission. Yet aside from determining the timing of the post-hospital follow-up appointment, the ideal visit content has received relatively little attention in primary care physician training and certification from the American Boards of Family Medicine and Internal Medicine. Similarly, the approach to the post-hospital visit is not identified as a general competency in leading textbooks of ambulatory care medicine.[3–6]

It should also be noted that timely follow-up care can be especially challenging for patients without

an established primary care provider, given the extensive waiting times for a new patient to establish care in a primary care practice.[7]

Financial Alignment with Physician Practice

The large majority (78 percent) of primary care practices in the United States have five or fewer physicians supported by medical assistants and receptionists.[8] Typically, these ambulatory practices do not employ nurses, case managers, pharmacists, or social workers. The proposed checklist, therefore, is focused on the physician's role, although clinics that do have ancillary clinicians could determine how to share the work among team members. Further, some of the checklist elements could be performed in conjunction with health care professionals external to the practice working in community pharmacies, home health care agencies, federally sponsored Area Agencies on Aging, and other community-based service providers.

The checklist is intended to be compatible with the typical outpatient clinic routine and to suggest how time may be used most efficiently and effectively. "With all that needs to be done and the time constraints, a checklist can be a huge help," said Sophia Chang, M.D., director of the Better Chronic Disease Care program at the California HealthCare Foundation.

Primary care practices perform a significant number of non-compensated tasks that compete for time that could otherwise be devoted to direct patient care.[9–11] The recently enacted health reform law will likely increase these demands. Primary care clinics will need to be even more engaged in coordinating care across settings, accommodating an influx of Americans who recently obtained health care insurance, and reducing preventable hospital readmissions.[1]

A number of health care organizations have already begun to align financial incentives with the provision of timely post-hospital care. Capitol District Physicians' Health Plan in New York provides financial incentives for primary care physicians to see their patients within seven business days of discharge. If this visit is accomplished, the practice may bill at the highest evaluation and management code level for a follow-up visit and it also receives a $150 bonus payment. This program, coupled with a telephone assessment performed by a case manager, has reduced 30-day hospital readmission rates from 14 percent to 6 percent.

CareMore Health Plan and Medical Group in California has shifted the performance of post-hospital follow-up care from primary care physicians to its hospitalists. Each month, hospitalists are profiled based on their readmission rates and are given 30-day readmission rate targets. The hospitalists are financially rewarded when these targets are met or exceeded. Consequently, they are keenly engaged in post-hospital care and assume a major role in decisionmaking about its timing and mode. The hospitalist may see the patient one or more times in a follow-up clinic and/or perform follow-up telephone calls. The hospitalist determines when patients will resume care with their primary care physician.

Research Findings and Discussion

The evidence is mixed with regard to the overall value of the post-hospital visit. In a national examination of Medicare beneficiaries readmitted to the hospital within 30 days of discharge, only 50 percent had been evaluated by a physician in the ambulatory arena.[12] Hernandez and colleagues reported that patients with heart failure who were discharged from hospitals with lower rates of follow-up visits had a higher risk of 30-day readmission.[13] In another study, patients lacking follow-up with a primary care physician within four weeks of discharge from a tertiary care academic hospital had a ten-fold-greater risk for readmission.[14] Kaiser Southern California analyzed more than 100,000 hospital discharges and found that patients over age 65 were three times

more likely to be readmitted if they did not attend a post-hospital follow-up visit.

In contrast, a multi-center trial found that patients who received more intensive post-hospital primary care had significantly higher rates of readmission.[15] Further, another study found no difference in 30-day hospital readmission, emergency department visits, or mortality between those with and without a follow-up appointment.[16]

Some research suggests that communication between hospital physicians and primary care physicians is useful for reducing preventable hospital readmissions. Indeed, patients seen for a post-hospital follow-up visit by a physician who had received the hospital discharge summary were less likely to be readmitted.[17] Unfortunately, discharge summaries are often unavailable at the time of follow-up visits and they frequently lack critical information.[2, 18–20] Although the discharge summary should indicate who will assume care for the patient after discharge, one study found that approximately half did not.[21]

To ensure effective communication between inpatient and outpatient care physicians, Sharp Rees-Stealy developed a discharge task in the electronic health record that is sent from the hospitalist to the primary care physician. It contains three elements: (1) final reason for hospitalization; (2) recommended follow-up appointment interval; and (3) pending laboratory studies or key follow-up issues. These tasks have been reportedly well received by primary care physicians, who appreciate the brevity and action-orientation of the communication.

National guidelines and quality collaboratives primarily address issues of timing and accountability for post-hospital care. The Transitions of Care Consensus Policy Statement proposes a minimum set of data elements that should always be part of the discharge or transfer summary and asserts that the sending clinician maintains responsibility for the care of the patient until the receiving clinician confirms assumption of responsibility.[2] Recommendations proposed by NCQA for the patient-centered medical home call for practices to have written standards for patient access, patient communication, and the coordination of follow-up for patients who receive care in inpatient and outpatient facilities.[22]

Co-sponsored by the American College of Cardiology and the Institute for Healthcare Improvement, the Hospital to Home (H2H) national quality initiative is an effort to improve the transition from inpatient to outpatient status for individuals hospitalized with cardiovascular disease. H2H recommends that follow-up visits be scheduled within a week of discharge.[23] National heart failure guidelines suggest recently discharged patients should be seen within seven to ten days.[24] In the CMS-sponsored Physician Group Practice Demonstration, The Everett Clinic and Geisinger Health System aimed for post-hospital follow-up appointments to occur within five days for high-risk patients.[25]

A number of local and national best practices provide important insights on the post-hospital visit. With support from The Commonwealth Fund, the Pacific Business Group on Health conducted a collaborative in California that focused on small physician practices with limited resources.[26] Key strategies that translated into significant increases in patient-reported improvements in care coordination included:

- Reviewing options for seeking care after hours;
- Providing the patient with a copy of the newly reconciled medication list;
- Reviewing consultants' notes prior to the visit; and
- Creating advanced clinic access appointments.

Monarch Healthcare Group is an Orange County-based IPA that works with its physicians to ensure that patients

who telephone their practices outside of normal operating hours receive recorded information on their options for seeking care.

A number of alternatives to traditional post-hospital visits have been explored. These include visits by physicians other than the primary care physician, open-access discharge clinics, drop-in shared medical appointments, and physician home visits.[27–30] Health Care Partners aims to have every hospitalized patient seen within 48 hours after discharge in a post-hospital clinic run by its hospitalist service. For patients who are not able to come to the clinic, Health Care Partners sends either a nurse practitioner or physician to make a home visit.

There has been considerable interest in the role of post-hospital phone calls in addressing quality and safety concerns, including those that pertain to medication safety. However, the current evidence is mixed as to whether telephone follow-up performed by hospital or case management personnel is an effective strategy for detecting medication errors and reducing readmissions.[31]

Laying the Groundwork for Cross-Setting Communication

To ensure effective post-hospital visits, the practice should take steps to systematize cross-setting communication and collaboration. In particular, it needs to develop specific communication strategies with hospital and emergency department physicians. Protocols that need to be delineated include:

- Timing of communication related to admission and discharge;
- Mode of communication (e.g., office phone, cell phone, pager, fax, email);
- Process and accountability for scheduling post-hospital follow-up visits; and
- Specific elements of the hospital discharge summary or ED visit summary that are essential for appropriate follow-up care.

Many of these protocols are derived from the Transitions of Care Consensus Policy Statement, which seeks to transform the discharge summary from a historical record to a more anticipatory and action-oriented document.[2] The protocols recognize the importance of having the primary care physician — the end-user of the discharge summary — provide input into its content design. Thus the discharge summary uses a series of "if-then" statements to anticipate possible clinical scenarios that may manifest over the weeks after discharge, along with recommendations for adjustments to the treatment plan.[32] For example, the hospitalist team could predict the types of adjustments to the medication regimen a patient with heart failure may require in the days that follow discharge and recommend several anticipatory management steps.

The practice should also create scheduling capacity and advanced clinic access for timely (i.e., 24 to 72 hours) post-hospital or post-ED visits, and may want to allocate a longer duration for these appointments. Advanced clinic access refers to expanding patients' and family members' options for interacting with their health care team, including opportunities for in-person visits, after-hours care, phone calls, emails, and other services. Advanced clinic access requires flexible appointment systems that can accommodate customized visit lengths, same-day visits, scheduled follow-up, and multiple-provider visits.

Content of the Visit

The box on page 5 shows a proposed checklist for effective post-hospital follow-up visits. Although most elements are targeted to the primary care physician, some can be assigned to other staff as appropriate. It is divided into three sections.

- **Prior to the visit.** The first part of the checklist includes telephone reminders to encourage patients to keep their appointments and, where appropriate,

Checklist for Post-Hospital Follow-Up Visits

Prior to the Visit

- ☐ Review discharge summary.
- ☐ Clarify outstanding questions with sending physician.
- ☐ Reminder call to patient or family caregiver to:
  - ☐ Stress importance of the visit and address any barriers.
  - ☐ Remind to bring medication lists and all prescribed and over-the-counter preparations.
  - ☐ Provide instructions for seeking emergency and non-emergency after-hours care.
- ☐ Coordinate care with home health care nurses and case managers if appropriate.

During the Visit

- ☐ Ask the patient to explain:
  - ☐ His/her goals for visit.
  - ☐ What factors contributed to hospital admission or ED visit.
  - ☐ What medications he/she is taking and on what schedule.
- ☐ Perform medication reconciliation with attention to the pre-hospital regimen.
- ☐ Determine the need to:
  - ☐ Adjust medications or dosages;
  - ☐ Follow up on test results;
  - ☐ Do monitoring or testing;
  - ☐ Discuss advance directives;
  - ☐ Discuss specific future treatments (POLST).
- ☐ Instruct patient in self-management; have patient repeat back.
- ☐ Explain warning signs and how to respond; have patient repeat back.
- ☐ Provide instructions for seeking emergency and non-emergency after-hours care.

At the Conclusion of the Visit

- ☐ Print reconciled, dated, medication list and provide a copy to the patient, family caregiver, home health care nurse, and case manager (if appropriate).
- ☐ Communicate revisions to the care plan to family caregivers, health care nurses, and case managers (if appropriate). Consider skilled home health care or other supportive services.
- ☐ Ensure that the next appointment is made, as appropriate.

identify barriers that can be addressed, such as transportation problems. Given the high rate of post-hospital medication errors and discrepancies, patients should be reminded to bring all of their medications (including over-the-counter preparations and supplements) and medication lists.

- **During the visit.** The visit is an optimal time to use "teach-back"—asking patients to explain in their own words or demonstrate what they have been told—to ensure comprehension of the instructions provided for managing their conditions. There is expanding evidence that teach-back is an effective technique.[33,34]

  The clinician can call attention to potential "red flags" or warning signs and symptoms that indicate a worsening condition, and explain options for seeking care during regular office hours as well as evenings or weekends.[35] The clinician can explore whether patients are eligible and would benefit from referral for skilled home health care services.

  A crucial part of the visit is a comprehensive medication reconciliation that begins with asking the patient an open-ended question regarding what medications he or she is taking and how they are being taken. In this manner the clinician avoids what may be a false assumption that the medications on the hospital discharge list reflect what the patient is actually taking. To identify and address discrepancies, the patient's actual regimen is compared with the pre-hospital regimen detailed in the ambulatory record and the regimen stated on the discharge summary.

- **At the conclusion of the visit.** The final section of the checklist addresses the conclusion of the visit and anticipates the next steps in care. The clinician ensures that the patient has a copy of the newly reconciled medication list and understands when to follow up with the practice by phone or in person. Important modifications to the care plan and medication list should then be conveyed to other professionals involved in the patient's overall care such as home health care nurses, case managers, and family caregivers.

An Ongoing Process

The proposed checklist is not intended to be a standard of practice, and should be considered an evolving document. Its purpose is to foster physician engagement in a national dialogue regarding roles and accountability for patients transitioning from the hospital back to the ambulatory arena. "After a hospital stay, patients really need their doctors to help them manage at home and avoid hospital readmission," emphasized Dr. Chang of the California HealthCare Foundation.

Physicians are encouraged to explore the adoption of the proposed protocols within their outpatient practices. Discussion and refinement of the checklist based on such broad practice experience will make it a more valuable tool in reducing unnecessary readmissions.

About the Author

Eric A. Coleman, M.D., M.P.H., is a professor of geriatric medicine and director of the Care Transitions Program, University of Colorado, Denver.

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About the Foundation

The California HealthCare Foundation works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at www.chcf.org.

Endnotes

1. 110th Congress. Patient Protection and Affordable Care Act of 2010, HR3590 (accessed June 27, 2010) www.opencongress.org/bill/111-h3590/text.

2. Snow, V., D. Beck, T. Budnitz, D. Miller, J. Potter, R. Wears, et al. "Transitions of Care Consensus Policy Statement: American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians and Society of Academic Emergency Medicine." *Journal of Hospital Medicine* 2009; 4(6): 364–370.

3. Goroll, A., A. Mulley. *Primary Care Medicine: Office Evaluation and Management of the Adult Patient.* Fifth ed. Philadelphia: Lippincott Williams & Wilkins, 2005.

4. Barker, R., J. Burton, P. Zieve. *Principles of Ambulatory Medicine.* 5th ed. Baltimore: Williams & Wilkins, 1999.

5. Duthie, E., P. Katz, M. Malone. *Practice of Geriatrics.* Fourth ed. Saunders, 2007.

6. Bodenheimer, T., K. Grumbach. *Improving Primary Care: Strategies and Tools for a Better Practice.* First ed. McGraw-Hill Medical, 2006.

7. Merritt Hawkins & Associates. 2009 Survey of physician appointment wait times. 1–17. 2009.

8. Bodenheimer, T., H. Pham. "Primary Care: Current Problems and Proposed Solutions." *Health Affairs* (Millwood) 2010; 29(5):799–805.

9. Baron, R. What's Keeping Us So Busy in Primary Care? A Snapshot from One Practice. *New England Journal of Medicine* 2010; 362(17):1632–1636.

10. Gottschalk, A, S. Flocke. "Time Spent in Face-to-Face Patient Care and Work Outside the Examination Room." *Annals of Family Medicine* 2005; 3(6):488–493.

11. Farber, J., A. Siu, P. Bloom. "How Much Time Do Physicians Spend Providing Care Outside of Office Visits?" *Annals of Internal Medicine* 2007; 147(10): 693–698.

12. Jencks, S., M. Williams, E. Coleman. "Rehospitalization among Patients in the Medicare Fee-for-Service Program." *New England Journal of Medicine* 2009; 360(14):1418–1428.

13. Hernandez, A., M. Greiner, G. Fonarow, B. Hammill, P. Heidenreich, C. Yancy, et al. "Relationship Between Early Physician Follow-up and 30-day Readmission among Medicare Beneficiaries Hospitalized for Heart Failure." *JAMA* 2010; 303(17):1716–1722.

14. Misky, G., H. Wald, E. Coleman. "Post-hospitalization Transitions: Examining the Effects of Timing on Primary Care Provider Follow-up." *Journal of Hospital Medicine* 2010; DOI 10.1002/jhm.666.

15. Weinberger, M., E. Oddone, W. Henderson. "Does Increased Access to Primary Care Reduce Hospital Readmissions?" *New England Journal of Medicine* 1996; 334(22):1441–1447.

16. Grafft, C., F. McDonald, K. Ruud, J. Liesinger, M. Johnson, J. Naessens. "Effect of Hospital Follow-up Appointment on Clinical Event Outcomes and Mortality." *Archives of Internal Medicine* 2010; 170(11):955–960.

17. van Walraven, C., R. Seth, P. Austin, A. Laupacis. "Effect of Discharge Summary Availability During Post-discharge Visits on Hospital Readmission. *Journal of General Internal Medicine* 2002; 17(3):186–192.

18. Kripalani, S., F. LeFevre, C. Phillips, M. Williams, P. Basaviah, D. Baker. "Deficits in Communication and Information Transfer between Hospital-based and Primary Care Physicians: Implications for Patient Safety and Continuity of Care." *JAMA* 2007; 297(8):831–841.

19. Kripalani, S., C. Phillips, P. Basaviah, M. Williams, S. Saint, D. Baker. "Deficits in Information Transfer from Inpatient to Outpatient Physician at Hospital Discharge: A Systematic Review." *Journal of General Internal Medicine* 19[S1], 135. 2004.

20. Bell, C., J. Schnipper, A. Auerbach, P. Kaboli, T. Wetterneck, D. Gonzales, et al. "Association of Communication between Hospital-based Physicians and Primary Care Providers with Patient Outcomes." *Journal of General Internal Medicine* 2008; 24(3):381–386.

21. Were, M., X. Li, J. Kesterson, J. Cadwallader, C. Asirwa, B. Khan, et al. "Adequacy of Hospital Discharge Summaries in Documenting Tests with Pending Results and Outpatient Follow-up Providers." *Journal of General Internal Medicine* 2009; 24(9):1002–1006.

22. NCQA. PPC-Patient-Centered Medical Home (accessed June 27, 2010) www.ncqa.org/tabid/631/default.aspx.

23. Institute for Healthcare Improvement. Hospital 2 Home (H2H) Excellence in Transitions (accessed June 27, 2010) www.h2hquality.org.

24. Hunt, S., W. Abraham, M. Chin, A. Feldman, G. Francis, T. Ganiats, et al. ACC/AHA 2005 guideline update for the diagnosis and management of chronic heart failure in the adult: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (writing committee to update the 2001 guidelines for the evaluation and management of heart failure): developed in collaboration with the American College of Chest Physicians and the International Society for Heart and Lung Transplantation: endorsed by the Heart Rhythm Society. Circulation 2005; 112(12):e154 – 235.

25. Kautter, J., G. Pope, M. Trisolini, S. Grund. "Medicare Physician Group Practice Demonstration Design: Quality and Efficiency Pay-for-Performance." *Health Care Finance Review* 2007; 29(1):15–29.

26. *A Quick Reference Guide: Improving the Patient Experience.* California Quality Collaborative, pp. 1–11 (accessed June 14, 2010) www.calquality.org.

27. Hendrix, C., M. Heflin, J. Twersky, C. Knight, J. Payne, J. Bradford, et al. "Post-hospital Clinic for Older Patients and their Family Caregivers." *Annals of Long-Term Care* 16[5]. May 1, 2008.

28. Noffsinger, E., J. Scott. "Understanding Today's Group Visit Models. *Group Practice Journal* 1999; 48(3):46–58.

29. Sikon, A., D. Bronson. "Shared Medical Appointments: Challenges and Opportunities." *Annals of Internal Medicine* 2010; 152(11):745–746.

30. Beck, R., A. Arizmendi, C. Purnell, B. Fultz, C. Callahan. "House Calls for Seniors: Building and Sustaining a Model of Care for Homebound Seniors. *Journal of American Geriatrics Society* 2009; 57(6):1103–1109.

31. Mistiaen, P., E. Poot. Telephone follow-up, initiated by a hospital-based health professional, for postdischarge problems in patients discharged from hospital to home. [Review] [358 refs]. Cochrane Database of Systematic Reviews 2006; 4(CD004510).

32. Coleman, E. "Safety in Numbers: Physicians Joining Forces to Seal the Cracks During Transitions. *Journal of Hospital Medicine* 2009; 4(6):329–330.

33. Schillinger, D., J. Piette, K. Grumbach, F. Wang, C. Wilson, C. Daher, et al. "Closing the Loop: Physician Communication with Diabetic Patients Who Have Low Health Literacy. *Archives of Internal Medicine* 2003; 163(1):83–90.

34. Weiss, B., J. Schwartzberg, M. Williams, T. Davis, R. Parker, P. Sokol. *Health Literacy and Patient Safety: Help Patients Understand.* 2nd ed. 2009.

35. Coleman, E., C. Parry, S. Chalmers, S. Min. "The Care Transitions Intervention: Results of a Randomized Controlled Trial." *Archives of Internal Medicine* 2006; 166(17):1822–1828.

Appendix A: Interviewees

Douglas Allen, M.D., M.M.M.
Vice President, Clinical Services
CareMore Health Plan

Nancy Boerner, M.D., M.B.A.
Vice President,
Quality & Medical Affairs
Monarch Health

Stuart Levine, M.D.
Corporate Medical Director
Health Care Partners

Martin Lustick, M.D.
Senior Vice President,
Corporate Medical Director
Excellus BlueCross BlueShield

Kirk Panneton, M.D.
Medical Director
Capitol District Physicians' Health Plan in New York

Jerry Penso, M.D., M.B.A.
Associate Medical Director, Quality Programs
Sharp Rees-Stealy Medical Group

Jill Uhle, R.N., M.S.N.
Senior Nurse Consultant, Improvement Advisor
Clinical Information and Performance Evaluation
Kaiser Permanente