Re-Engineering discharge from the emergency room: Identification of processes that impede effective communication about the importance of follow-up care

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INTRODUCTION

Numerous studies across the US have shown that patients seen in an emergency department (ED) for chronic disease complications incur a higher risk of readmission rates and are more likely to experience poor short and long-term outcomes. Follow-up care following emergency treatment for chronic disease is known to effectively mitigate such risk. Since 2012, the ED at University Hospital (UHS) partnered with the UHS Ambulatory Connections clinic to provide follow-up care for individuals treated at the UHS ED for chronic disease complications. The partnership facilitates rapid outpatient follow-up visits for patients discharged from the UHS Emergency Department (UHS/ED) with the goals of 1) preventing subsequent ED visits or hospitalizations, 2) transition to a medical home, and 3) identification of eligibility for Medicaid enrollment

Since the inception of this partnership in 2012, the "no-show" rate for follow-up appointments has been difficult to address. Most concerning is that in the last 18 months, the "no-show" rate for follow-up appointments has consistently varied between 50 – 80%. For this project *we sought to identify processes in the Emergency Department that conferred the risk of a no-show for a follow-up appointment.* We were specifically interested in the communication and information dissemination that occurred before discharge from the ED; processes that have been shown to affect "no-show" rates for post-ED follow-up appointments.

APPROACH

The target population for this quality improvement project were patients who:

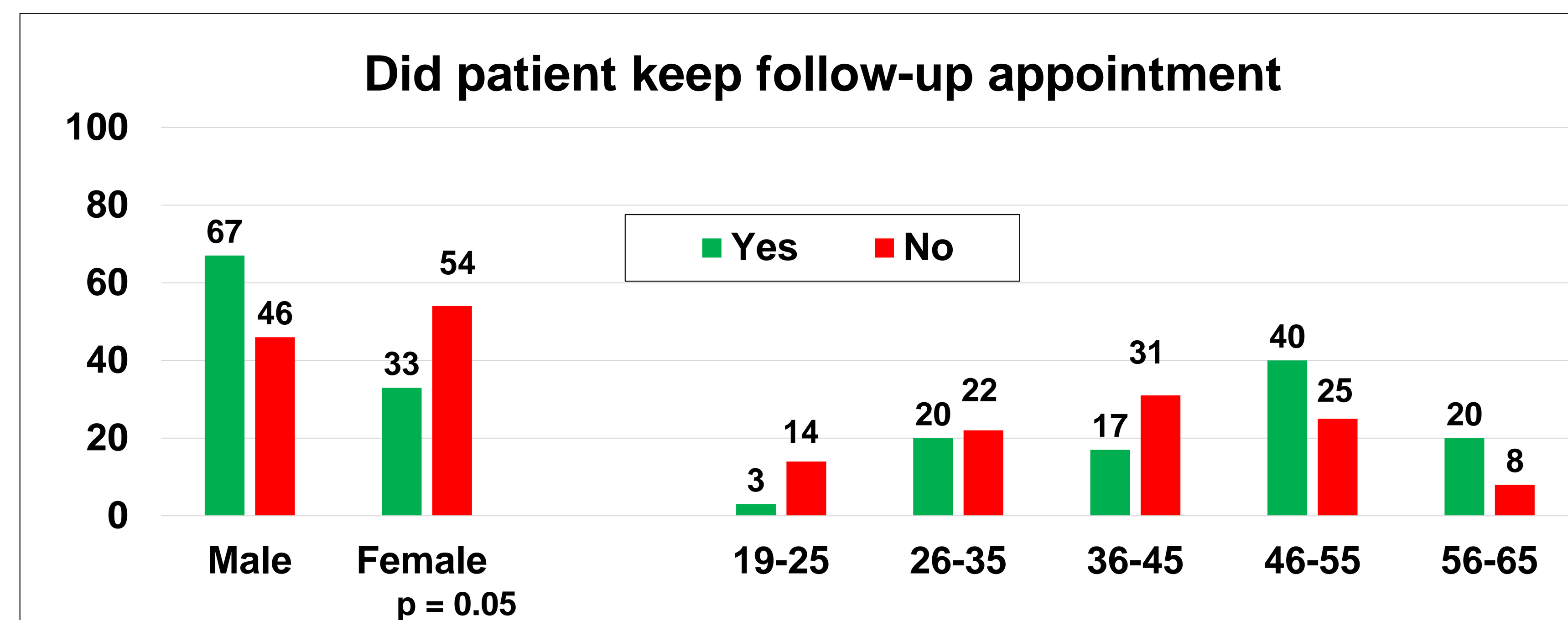
- Were treated in the UHS ED for chronic disease complications
- Referred for a follow-up appointment at the UHS Ambulatory Connections (AMC) clinic located at the Robert B. Green campus
- Lack a usual source of care (e.g., PCP or PCMH)

A daily patient list identified patients with follow-up orders to the AMC clinic documented in their electronic medical record.

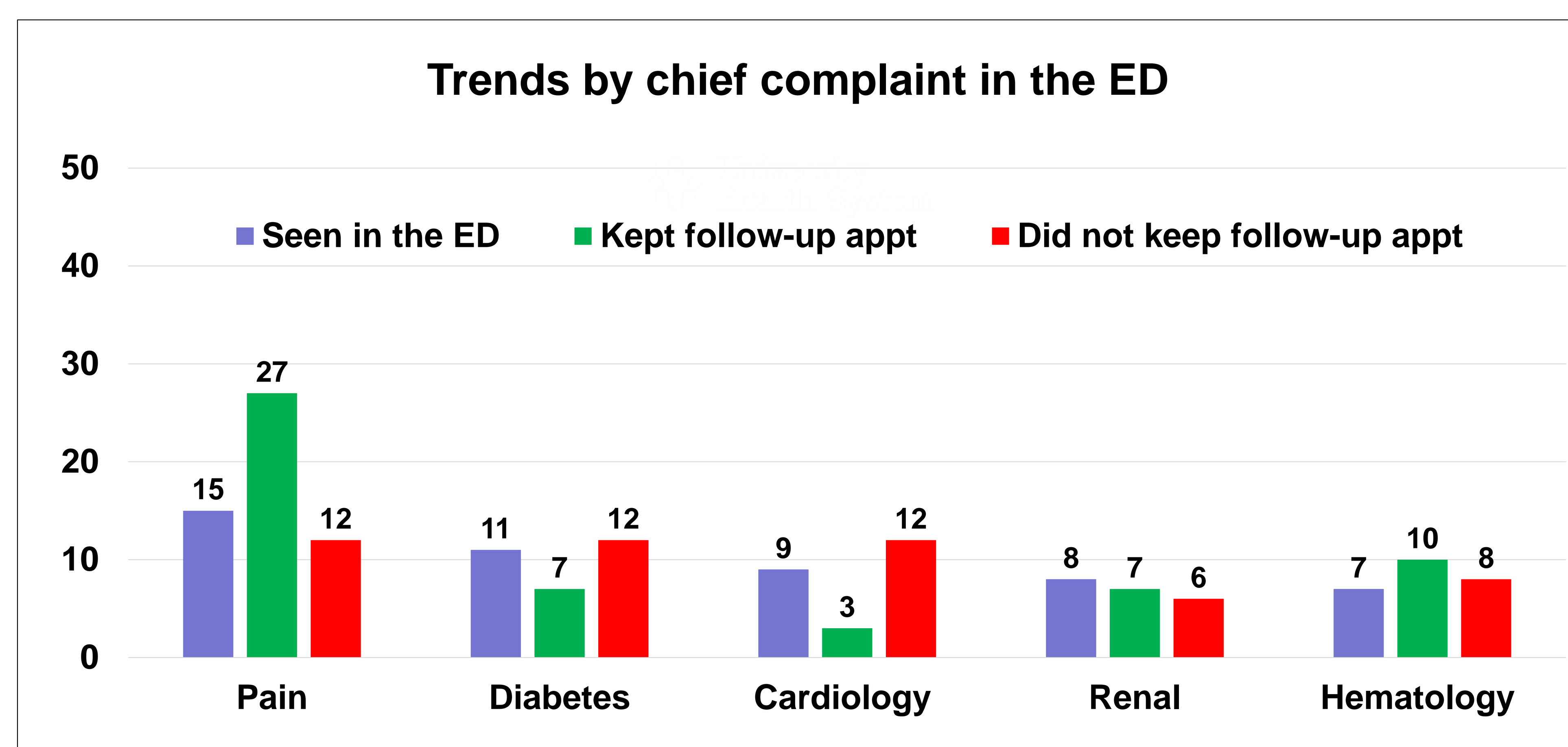
Within 7 – 10 days following the ED visit a chart review of the aforementioned patients was performed to determine if the patient was able to keep their follow-up appointment

For those not able to keep their appointment, a follow-up phone call was made to distill ED processes that served as barriers to follow-up care

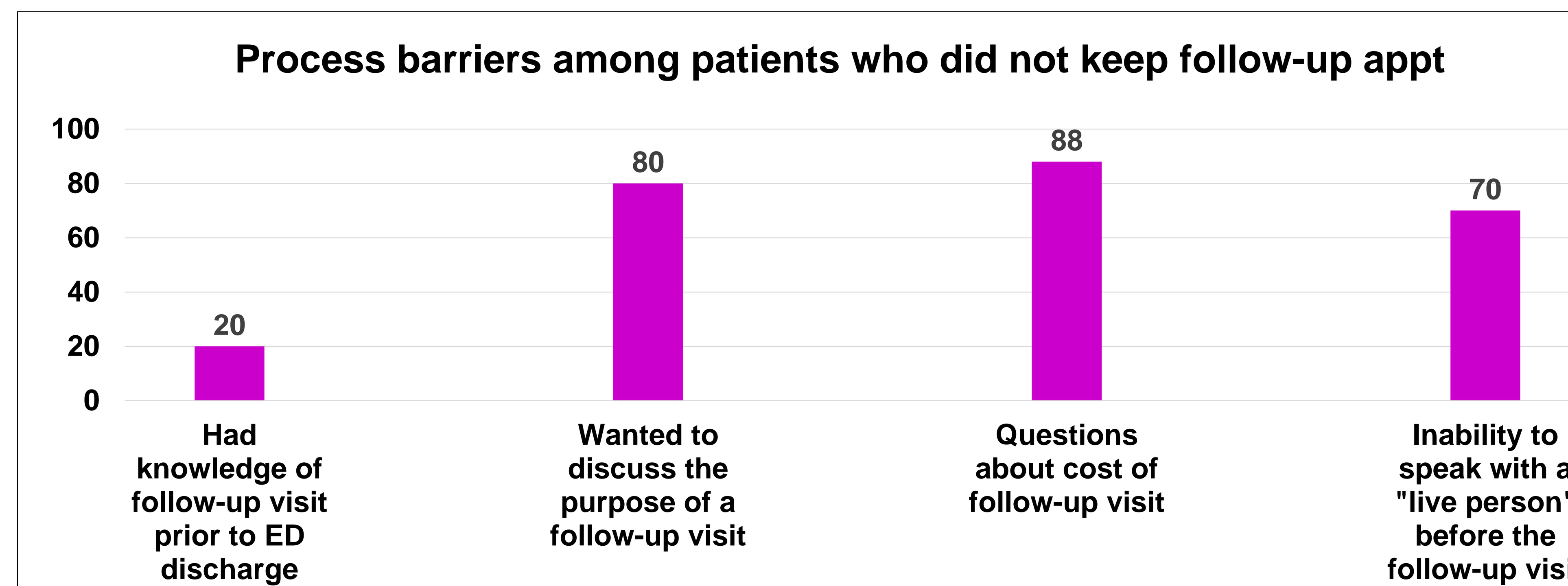
RESULTS



Finding: Males were more likely to keep their follow-up appointment when compared to females. This is contrary to national trends of males having poor health-seeking behavior when compared to females. We also found that age category was not a significant predictor of keeping a follow-up appointment



Finding: When examining the trends of chief complaints for patients who received a follow-up referral to the AMC, 50% were seen in the UHS ED for pain (chest or abdominal), cardiovascular symptoms, renal complications, and hematological disorders.



Key Finding: Patients consistently reported that the "robo-call" automatic telephone reminders played a significant role in deciding not keep their follow-up appointment.

RE-ENGINEERING EFFORTS

The UHS/ED pre-discharge process now includes a bedside visit by the ED care coordinator to discuss the follow-up appointment.

The pre-discharge visit also includes a discussion regarding the purpose of the follow-up appointment and a direct phone number to the ED care coordinator for further questions.

The ED care coordinator's team conducts telephone follow-up calls within 2 -3 days of discharge from the ED.

Preliminary results from our process re-engineering indicate a 40% reduction in the "no-show" rate among referred patients.

This suggests that timing of information dissemination prior to ED discharge has significant implications on quality of care.

FUTURE DIRECTIONS

Reduce follow-up phone call time to within 24 hours from ED discharge

Develop a shared decision-making framework within the ED specifically focused on social and economic barriers to follow-up care

Expand bedside education regarding follow-up appointments for patients who are referred to specialty care such as neurology, rheumatology, and pulmonology

Develop a care coordination toolkit that would serve as an inventory for best practices resulting from this project

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