Improving 7-day follow-up: Yes, but….

Preamble: When AFHTO are asked they agree that follow-up is important, but…. This note presents potential solutions to help get past the "Yes, but…" stage some teams find themselves in when trying to do more to track and improve follow-up.

"Yes, but..." #1: The 7-day follow-up indicator only includes visits to physicians and depends on notification of discharge by hospitals, which for the most doesn't happen in a timely way (or at all).

> Not true. AFHTO members have developed a new indicator that includes follow-up by any member of the team by phone or in person for all patients for whom you have received hospitalization information. The definition has been adopted by HQO as part of the QIP suite of indicators. The new definition still depends somewhat on getting information from hospitals about discharges. This is true of any definition of follow-up. However, lack of access to information from hospitals does not preclude teams from recording the follow-up they do for patients they *do* know about.

"Yes, but..." #2: It takes more effort to capture the data for new indicator relative to getting the data from the Health Data Branch portal.

> True. If you are more concerned about the work associated with tracking phone encounters by staff in a consistent way in your EMR, you can choose to stick with the easy-to-access data in the portal (even though you disagree with the definition) or you can choose to not measure follow-up at all. The majority of AFHTO members chose the latter option in D2D 1.0 and have continued to choose this in each of the 7 iterations that followed over the subsequent 3.5 years later. This choice makes it impossible to demonstrate the value of teams in a crucially important aspect of AFHTO's strategy: making the case for the role of teams in coordinating care for Ontarians.

"Yes, but..." #3: There is nothing primary care teams can do to get information about discharges from hospitals.

> Not true. Certainly, it is baffling and beyond that there still is no policy or process requiring hospitals to reliably, consistently and accurately provide discharge information to primary care providers. Accountability agreements between hospitals and LHINs include readmission and revisit rates but nothing about the requirement for sharing information with primary care providers. It is no wonder that primary care providers have such difficulty getting this information. Nevertheless, it is not impossible. Many primary care teams have developed strategies to get discharge information. Some of the solutions are summarized in the Appendix (which you will note was produced in 2014). Since then, a few other ways to get information from hospitals have emerged, including an innovative patient-centered approach called "patient oriented discharge summaries" (PODS). All of these approaches require some work and relationship-building. As long as you are unable to commit effort to getting these data, you may have to accept that your patients may end up falling through the cracks after hospitalization.

"Yes, but..." #4: Not all patients need to be followed up after hospitalization.

True. And 4 years of extensive consultation and review of literature has failed to result in a solid consensus about which patients DO need follow-up after hospitalization. Some clinicians feel it is not necessary to follow mothers after healthy deliveries. Others feel follow-up regarding breast feeding is useful. Some clinicians feel that patients with one or more of the more commonly discussed chronic conditions really need follow-up. Others feel that these patients are more appropriately followed by specialists, making follow-up by primary care unnecessary. Some clinicians who are actively involved in managing and discharging patients from hospitals feel that follow-up by the team is not necessary. Others feel that a follow-up about medication use and/or progress with home-based instructions is useful, even for patients they managed in the hospital. The difficulty in generating consensus about the appropriate target population of patients is compounded by the dearth of concrete evidence about the impact, the most effective modes and the best timing of follow-up. Finally, even if consensus about patient population could be reached, it is virtually impossible for any of the systems for getting hospitalization data to include information about the relevant patient characteristics. The solution to this conundrum is therefore to include *all* patients and accept that the target rate for follow-up is not 100%, at the same time as conversation and participation in research continues to try find a better solution.

"Yes, but..." #5: Teams have no control over physician workflow and therefore can't do or track follow-up.

Not true. Many teams have found ways to make it easier for physicians and their staff to either do or share roles in follow-up after hospitalization. Briefly, these include assigning a staff member to make phone calls or sort through incoming HRM messages. Some teams have focussed on patients with multiple medications and have assigned follow-up to pharmacists. The bottom line is that doing follow-up is more work than not doing it. However, many teams have found that doing follow-up pays off even in terms of staff time because of the reduction in calls and visits due to patients falling through the cracks. AFHTO has no concrete data about this yet (because so few teams report the data) but individual teams report that they feel outcomes of patients (including deepening of the relationships with patients) are other benefits reaped from their additional effort to do and track follow-up.

"Yes, but..." #6: It is not possible to track follow-up done by non-physicians.

> Not true. Certainly, physician billing data does not, by definition, include any activity other than that done and billed by physicians. However, physician billing data is neither the only nor the best source of data for tracking and demonstrating the value of teams in primary care. EMRs are far better for this purpose. Several solutions have been developed by teams to track follow-up activity in 5 different EMRs, regardless of who does it (physician or other clinician) and how it happens (phone or in-person). Teams need to have a really good understanding of how many and what type of interactions staff have with patients for ANY reason, not just follow-up after hospitalization. Teams who prioritize this knowledge can use queries and tools developed by QIDSS to enter and extract these data from their EMRs.

"Yes, but..." #7: There is no evidence that follow-up within 7 days makes any difference.

> Only partly true. There is not much evidence in the literature regarding the effectiveness of follow-up[1]. However, there is some. Some have found that "timely" follow-up was associated with reduced readmissions[2] and others have suggested that non-physician follow-up could be beneficial[3]. Disease-specific studies are more clear – for example, one study shows the benefit of follow-up of patients with heart failure within 48 hours of discharge[4]. Nevertheless, there is wide-spread belief that follow-up after hospitalization is a key "care coordination" role of primary care teams and a big part of their contribution to keeping patients from falling through the cracks. There is, however, much more contention about the right interval for follow-up. 48 hours is very defensible from the evidence. However, this is roundly dismissed as impractical by providers and policy-makers alike. 7 days is admittedly an arbitrary attempt at quantifying the concept of "soon after hospitalization". The choice of 14 days for physician billing purposes is equally arbitrary and is one of the intervals for which there is solid evidence of LACK of impact[5]. The choice of 7-days is no more rational than any other number between 2 and 14 but at least it is aligned to current workflows (if any) and other primary care reports.

Appendix

follow-up data access solutions 3.d

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[1] Misky, G. J., Wald, H. L., & Coleman, E. A. (2010). Post-hospitalization transitions: Examining the effects of timing of primary care provider follow-up. *Journal of Hospital Medicine*, *5*(7), 392-397.

[2] Lapointe-Shaw, L.,Mamdani, M., Luo, J., Austin, P.C., Ivers, N.M., Redelmeier, D.A., Bell, C.M. (2017) Effectiveness of a financial incentive to physicians for timely follow-up after hospital discharge: a population-based time series analysis, CMAJ October 02, 2017 189 (39) E1224-E1229; DOI: https://doi.org/10.1503/cmaj.170092 http://www.cmaj.ca/content/189/39/E1224

[3] Grafft, C. A., McDonald, F. S., Ruud, K. L., Liesinger, J. T., Johnson, M. G., & Naessens, J. M. (2010). Effect of hospital follow-up appointment on clinical event outcomes and mortality. *Archives of internal medicine*, *170*(11), 955-960.

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[5] Kashiwagi, D. T., Burton, M. C., Kirkland, L. L., Cha, S., & Varkey, P. (2012). Do timely outpatient follow-up visits decrease hospital readmission rates?.*American Journal of Medical Quality*, *27*(1), 11-15.