Follow-up stories from teams

Preamble: The following is direct extract of stories provided by teams about follow-up processes in D2D 2.0, 4.0 and 4.1 and, in the second table, from QIP reports.

D2D stories

At our rural site, our physicians work in their clinic but also the local hospital ward. As such, they routinely follow the progress of their inpatients and are able to determine before they even leave the hospital when/if they need to be seen for follow-up post-discharge. We are committed to patient-centred care instead of the blanket approach recommended by the Ministry, and therefore set our own target of providing follow-up within 14 days for all patients who require it and more urgent follow-up when needed.
Our Welcome Home Program which consists of a nurse practitioner and registered nurse receives discharge notifications from 4 floors at our local hospital Peterborough Regional Health Centre (PRHC.) Upon receiving a discharge notification, the Welcome Home program ensures that appropriate follow-up care is arranged. In some cases, this is with the patient's family physician however follow-up may be conducted by a nurse practitioner or another health care provider. In some cases, follow-up is completed by a specialist if this is deemed to be most appropriate. For each discharge notification received, we track the patient's name, family health organization (FHO), family physician, the case mix group (CMG) to which their diagnosis falls into, date of discharge, disposition, date of follow-up appointment, date seen by FHO, date seen by specialist (if applicable), and readmission date (if applicable.) For patients with a disposition of home, and whose diagnosis falls into one of the applicable CMG categories (i.e. Stroke (Age >45), COPD (Age >45), Pneumonia (All ages), Congestive Heart Failure (Age >45), Diabetes (all ages), Cardiac CMGs (Age >40), and Gastrointestinal CMGs (All ages)), we calculate how many were followed up by either a health care provider within the FHO or a specialist (if/when appropriate) within 7 days from their date of discharge. % seen within 7 days (certain CMGs, disposition = Home) = # of patients with disposition of home whose diagnosis falls into one of the specified CMGs, and who has received appropriate follow-up care by either the FHO or a specialist within 7 days of discharge / # of patients with disposition of home whose diagnosis falls into one of the specified CMGs, and who has received appropriate follow-up care by either the FHO or a specialist
Our team tracks all discharge reports received. From April 14 to Mar 15 we receive 171 discharge reports. 65% were received within 7 days post discharge. We were able to contact 57% of patients within 7 days post discharge. Each patient was offered an appointment. However many patients do not wish to visit their PCP so soon after discharge from hospital. From our first year of tracking we have two key learnings: - Hospitals do not consistently issue discharge reports and if they do, it is often not within sufficient time for us to receive then invite the patient to an appointment within 7 days of discharge. Greater emphasis should be placed on tracking the production of discharge reporting by hospitals. - Some patients do not wish to make the extra trip out to visit their PCP so soon after hospital discharge. In a patient centred clinic, we track the rate of patient contact and not actual clinic appointments.
Local hospital is sending bi-weekly reports with discharge information. This is a pilot project with information from one unit only not whole hospital.
Our FHT has several sites, but we decided it would be an important Quality initiative to perform Medication Reconciliations for our patients when they are discharged, and when possible, admitted to a local hospital. Each day, a nurse at each of our sites will retrive the admission/discharge report from the local hospital and perform a medication reconciliation where possible. At that same time, they will check if the diagnosis linked to the stay was one of the Case Mix Groups identified in the QIP as patients needing follow-up within 7 days post hospital discharge. If so, our nurse will attempt to schedule follow-up for that patient to see their family physician. Our team created a data capture tool so we could track the adoption of this new process across the sites, which has been used for over a year. While our rates of medication reconciliation being complete is over 90%, our ability to schedule follow-up within 7 days for the patients who need it varies by site and physician.
Hospital data is pulled from Windsor Regional Hospital's admission system. Tracking system for CTAS 1,2 and 3 regardless of the condition. These data are integrated into a running document used for ongoing tracking, trending, performance measurement, patient management and coordination. The reports are available daily for primary care

providers to review at the Windsor FHT site. A specific EMR appointment type was created to accommodate hospital related follow-ups. Doctors are shown to complete the hospital discharge sheets daily to indicate whether a follow-up is necessary after reviewing patient information. The data is monitored, tested and evaluated to ensure the quality of data is accurate, useful and the program is on track. Over time the FHT will be able to know the following: Number of patients accessing ED and inpatient hospital services Number of patients requiring a priority appointment within 7 days of discharge Number of patients attending their priority appointment within 7 days of discharge Number of patients not requiring follow up by primary care but requiring education if reason for hospital utilization was deemed to be for a condition best managed elsewhere Number of patients discharged but readmitted within 30 days Number of patients discharged, categorized by CMG
We aim to follow up all in patient discharges with a phone call from our RPN. We do not limit our follow-up calls to the selected conditions list. We use an Encounter Assistant in Telus EMR to track the phone calls. When the RPN is away, reception or clinical assistants make the calls. Sometimes technical difficulties mean we do not call everyone within our goal timeframe. (Meditech access and internet connectivity issues). Appointments are booked for patients for the following reasons: - patient requests an appt - hospital booked an appointment - RPN or reception decides pt needs an appt These appointments are booked within the timeframe that is deemed appropriate depending pt, results, specialist consults and appointment availability etc.
The result is from the MOHLTC Heath data branch portal and is based on final data for FY 2013/14 and interim data for FY 2014/15.
Measure: 7-Day Post Discharge Primary Care Visit for patients with one or more of the following conditions: Stroke, COPD, Pneumonia, Congestive Heart Failure, Diabetes, Cardiac, GI problems Method: 1. Educated physicians and office staff on patient discharge summaries that require immediate action. 2. Defined and supported the implementation of a timely process in each physician's office for prompt recognition and follow up a. Physician's office contacted appropriate patients to book follow up appointments within allocated timeframes 3. Created a data entry sheet for physician's offices to track patients who required appointments within 7 days and to track appointments that actually happened 4. Collected, analyzed and reported findings to individual physician's offices for office process improvement where applicable 5. The numerator and the denominator is based on cross-sectional data during the period from Oct to Nov 2014.
The result is from the MOHLTC Heath data branch portal and is based on final data for FY 2013/14 and interim data for FY 2014/15.
Due to the inability of NPLC's to roster patients, data from ICES, SAR, MOHLTC & SAMI score is unavailable. N/A means data is not available. Seven day post hospital f/u is mostly done by patient self reporting.
7 Day follow-up team specific: Our team currently collects discharge data from the Horizon Physician Portal and via HRM. Our QIDSS created an excel file that highlights those who have been discharged from our local hospital. We define an office visit and/or telephone call as "follow-up." Our case manager completes the follow-up calls and provides patients additional resources should they need it. Please note that the current performance rate does not include our other satellite locations (this will be completed in the 2015-2016 year).
There is a process in place with the lcoal hospital to receive discharge reports of the STAR FHT pts who have had admissions to the hospital in this fiscal year. The discharge reports clearly outline admissions diagnosis. The HQO selected CMG's are matched to the pt's admission diagnosis and determined if they should receive f/u within 7-days

post discharge. (by phone, home, or office visit with RN, NP or physician) The CMG defined by HQO needs to be more definitive to help physicians discern which patients meet the 7-day f/u.
% of rostered patients who were seen within 7 days by MD: 34% Rostered patients with the discharge in FY 14-15 for selected conditions Other measure being collected: % of discharges received within 7 days
When the deay of dischrge is known, the Medication Reconciliation Program Administrator calls the patient and offers the a post hospital discharge follow-up appointment with the pharmacist. The patient either books or declines the appointment offer.
As of January 2015, Sault Area Hospital has started sending daily ER visit and discharge data. Tracking patients post discharge in real time with these reports will allow us to improve our follow up. Currently we are developing a tracking method to better coordinate services.
Medication reconciliation is completed for new patients.
We are currently coding all discharges for our local hospital in the EMR to allow us to run 7 day follow up for patients discharged from our local hospital. The next step will be to collect data for our patients from all hospitals.
Percent of patients/clients who see their primary care provider within 7 days after discharge from hospital for selected conditions (FY2013/14). Data from Health Data Branch Web Portal
Each site coordinator connects with the discharge planner at the hospital and then follows up manually with patients to get their appointment set up.
The discharge process we have implemented begins when we receive notification that a patient has been recently discharged from a hospital. Notification is done by means of a discharge summary, discharge notification or a verbal notification sometimes given by patient or patient's family member. A receptionist will then notify our Triage Family Practice Nurse, who will contact the patient by phone call. The phone call is to determine the reason for the recent hospital visit, how the patient is currently feeling, and if a follow-up appointment with the patient's family physician is necessary. The Triage Family Practice Nurse will book the appointment within 7 days post discharge. The Triage Family Practice Nurse will also chase test results or any necessary information for the visit. Finally, the Triage Family Practice Nurse will notify the patient's family physician of the recent discharge, regardless if a follow-up appointment was booked. Our nurses spoke to 82 patients post discharge (95%) . We saw 45 patients within 7 days post discharge. However, our nurses reported only 48 needed a follow up.
The hospital discharge program ensures patients receive follow up and care in the community post hospital discharge. It targets all patients discharged from hospital. Our physicians are part of a rotating on-call group that care for their own patients admitted to hospital under family medicine. Once a physician discharges a patient home, they notify appropriate clerical staff members at the FHT. This clerical staff member notifies the RN and books an appointment immediately with the patient's family doctor within 10 days, which the on-call physician provides to the patient during the discharge process. The RN performs a hospital discharge follow up call within 48 hours of being discharged. This hospital discharge procedure ensure that all appropriate community agency and specialty referrals will be reviewed, contacted and/or established at the 48hr phone call. For high risk patients a in-house pharmacy review is completed within 1 week of discharge. For a patient to be enrolled in this hospital discharge process, they must be discharged by a physician within the FHT. The FHT would like to include all their patient's no matter of the discharging physician. The City of Lakes FHT is working closely with Health Science North to receive information regarding admission and discharges in a timely manner.
The discharge monitoring process involves all patients active in the FHT who have been discharged from a tertiary care centre in the region. Source data is from Clinical Connect, a tracking system through which all information about hospital admissions and discharges are listed. Every Monday, the individual practice information is pulled and forwarded to a designated clinician to contact by phone all patients discharged in the last 7 days. This serves as the 'contact' date. Any patient who requires in clinic follow up (determined by the clinician in consultation with the team and not being seen by another specialist/other health provider) is scheduled for an appointment. This serves as the in-clinic/follow up date. Using these two dates, we are able to determine the time between discharge and contact +/- in person follow up. The goal is to make contact with patients within 7 days for either of these metrics. The systematic collection of data began at the end of 2014 and the data provided represents data compiled for the

last quarter (Jan-Mar 2015). The average time to contact (either phone or clinic) for clinic 1 and clinic 2 was 3.58 days, and 5.77 days respectively.
We have developed an EMR stamp to capture the Discharge date; Name of Hospital; Reason for Admission; and numerous factors about patient and visit. We find the figures we currently get on data portal for this indicator do not take into account the patients that the Nurse Practitioner would see as not picked up from MD billing codes. We have started a new process start of this fiscal year for our stamp to now include the provider who saw the patient so that we can now run stats on patients seen by NP's to know that variable. We continue to have an issue though with not being able to get information from hospitals when a patient is discharged, which would enable us to know patient was in hospital and may need 7 day follow up visit, depending on reason for admission. In our search from Apr 1, 2014 to March 31, 2015 we had used the stamp 79 times but we have not had the resources to reference this against the hospital data to determine our %.
We measure 7 day follow up for each provider quarterly. We search the EMR for discharge summaries and then manually review if the patient was seen in our office or by a specialist within 7 days of discharge if they have a qualifying discharge diagnosis.
Once our scanning department receives a discharge summary, it is taken to our Lead nurse. Our Lead nurse records them, looks into the chart to see if an appt has been booked already. Most often, the physician has read the summary report and requested the nurse to make a follow up appt. If the physician has not done this, the Lead Nurse will instruct the reception staff to book an appointment as of the date 7 days after discharge. The difficulty is not getting the discharge summaries in a timely fashion.
Data was retrieved from Health Data Branch Web Portal. We are currently in the process of launching an in house tracking mechanism.
We continue to work with local hospitals regarding admission of NP patients. Until we receive notification from hospitals of all NP patient admissions, there is no way for us to accurately measure the rate of 7 day follow-up. NP's provide a card with their contact information and educate patients on how to use it at hospital admitting. Targeted populations are new patients, previously hospitalized patients, and patients with chronic illnesses. Patient's are instructed to use the consulting physician's name if hospital admitting will not accept NP as primary care provider. Reports are generated from the EMR which provide numbers for each Q-code per month. The reports provide the following data: Total number of known patients who see their primary care provider within 7 days of hospital discharge (Q042A)/Total number of patients known to be hospitalized (Q041A+Q042A) and percent of known patients who see their primary care provider within 7 days after discharge from hospital for selected conditions [Q043A (stroke, COPD, pneumonia, congestive heart failure, diabetes, cardiac, GI complications)]/Total number of known patients who see their primary care provider within 7 days after discharged from hospital (Q042A).
Using LENS reports for our hospitalization data, we identified patients with the same conditions as defined in the MOHLTC measure. These diagnoses include renal failure, CHF, IHD, COPD, asthma, diabetes and frail elderly. Of these patients we used the EMR to track who had a follow-up within 7 days of discharge. Visits conducted by physicians and AHPs were included, as these patients often need home visits or more comprehensive visits which have been partially delegated to our AHPs through our Operational Plan. Visits were counted even if they were not billed with the billing code as tracked by the MOHLTC.
We did not attempt to calculate these indicators. Currently using HRM reports is not feasible for data mining given the format is text. Looking to create a process with hospital to extract discharge data for all FHT patients; similar to Health Link data extract.
The purpose of our admit/readmit prevention program is to prevent unnecessary readmission to hospital due to exacerbation of COPD. We provide education to make sure patients are taking prescribed medications and understand the technique of using inhalers, home oxygen etc. Follow up with physicians ensures they are improving. Most COPD patients have a previous, established diagnosis. Spirometry testing is done to confirm new diagnosis. We worked in partnership with our regional hospital to develop the process of receiving a daily generated patient list. The hospital creates a daily list of patients being discharged with a primary diagnosis of COPD and faxes it to our FHT. Our administrators transfer the patient list into our shared computer drive which is then checked by a member of our respiratory team who calls the patient within 48 hours of discharge. Using a callback questionnaire form (developed by our FHT), patients are contacted for a follow up appointment with their primary care provider or IHP (RT) within 7 days. This visit may be at the FHT or as a home visit if necessary. Patients residing in extended care facilities are not part of the project.

Our future goal is to have an action plan in place for all COPD patients. This project has proven very successful in that over 95% of the discharged patients are seen for a follow-up within 7 days by a Respiratory Therapist or Primary Care Provider.
List of discharged patients is generated daily for each physician via Clinical Connect. QIDSS developed toolbar to consistently record data in the EMR. Data is recorded and receptionists are asked to call patients in to be seen by MRP if no appointment has been booked. Search of EMR developed by QIDSS to track date of discharge vs date seen by MRP. Data can also be compared to search of billing code E080 to double check consistency of data.
% of patients discharged from St. Michael's Hospital and seen by a FHT MD or NP within 7 days of discharge
Hospital data is pulled from Chatham-Kent Health Alliance's admission system. These data are accessed through logging into a Phsiycian's Portal that reports daily admissions. This information is integrated into a running document used for ongoing tracking, trending, performance measurement, patient management and coordination. An algorithm has been created to streamline the follow-up process. A specific EMR appointment type was created to accommodate hospital related follow-ups. The data is monitored, tested and evaluated to ensure the quality of data is accurate, useful and the program is on track. Over time our FHT will be able to know the following: Number of patients accessing inpatient hospital services. Number of patients requiring a priority appointment within 7-14 days of discharge. Number of patients attending their priority appointment within 7 days of discharge, no showed or cancelled their booked follow-up appointments. Discharges by CMG and discharge status. Number of patients discharged but readmitted within 30 days.
Physicians and nursing team to continue to identify discharge summary reports and categorize them correctly in the EMR. Physician/NP to advise chronic disease RN using notification stamp. Chronic Disease RN will telephone all patients discharged from hospital and triage their needs (e.g. pharmacist - med reconciliation, MD visit, CCAC). Further education of clerical team in regards to booking patients as per information provided by RN (via stamp). A custom form will be created for the chronic disease RN to use when contacting patients post-discharge. She will document details, including whether the patient was contacted within 7 days of discharge. We will run regular searches for these custom forms to measure the percentage of patients contacted successfully within 7 days of discharge. In addition, the chronic disease RN will conduct quality assurance for the first 3 months of the project to assess the percent of discharge summaries appropriately referred to her and will educate physicians/NPs if eligible referrals were missed. This project is in alignment with St. Joe's corporate initiative on delivering standardized discharge communications for primary care and community partners.
We asked on our patient experience survey: "Were you seen by your health care provider within 7 days of being discharged from hospital?", options for answers: "yes", "no", "N/A"
We asked questions on patient experience surveys: "The last time you were discharged from hospital did you see your physician within 7 days of discharge?"
The 7 day follow up is from the MOH Portal data for 2013/14
Reporting on 7 day post-discharge follow-up rates has been difficult to interpret in a meaningful way, due to the delay in receiving data feedback from the MOH, and a perception that most system improvements would be out of our control. Our team set out to better understand our baseline, and this started with the recognition that our tracking process could only account for discharge reports actually received. The team saw that there was room for improvement and aimed to: 1. Increase the proportion patients who are seen within 7 days of hospital discharge (per MOH criteria) 2. Develop a system that enables meaningful, real-time data capture and feedback for ministry-prioritized indicators Our change ideas: 1. Create a process to ensure patients are followed upon discharge summary receipt. This required: engaging a broad team (admin, health records, nurse, pharmacist, MD, etc.), creating a process map, and a tracking sheet. 2. Obtain access to more accurate and timely information regarding patients who have been discharged from hospital by: a) analyzing patterns for discharges received by hospitals, b) proactively contacting health records departments of selected hospitals, and c) develop working relationships with selected hospitals. 3. Improve patient education on importance of follow-up

Outcomes/ Results to date (FY14/15 Q4): Primary outcome: 1. Proportion of patients seen within 7 days (meeting MOH criteria)= 32% Secondary outcomes: 1. Number of discharges meeting MOH criteria within 3 month time period= 82 (this represents 41% of all discharge summaries we received) 2. Number of patients connected with FHT pharmacist following discharge= 1 3. Identification of patterns from discharge sources a) Median number of days between date of discharge & date discharge was received by our clinic= 8 b) Identification of our top 5 sources for discharge summaries Lessons learned and next steps: It has become clear in our observations that we are receiving many of our discharges beyond the target date in which patients are supposed to be seen. Despite this, we
Used information from a previous similar internal discussion and report
The local hospital admin staff call our office to book a follow-up for the patient prior to discharge.
Still in the data collection stage from local hospital.
Still in the data collection stage from local hospital. Started receiving manual reports that ID our patient's discharges.
Using an Encounter Assistant within PSS, our nurses are continuously checking Clinical Connect for any recent hospitalizations. Once a patient has been discharged, the nurse uses the EA and will determine if a phone call is appropriate (some patients may be followed by a specialist or institutionalized). Regardless, all patients are followed up on and noted in their chart.
RN at each site ensures follow-up appointment with physician or FHT provider within 7-days of discharge when appropriate. Role is part of the medication reconciliation program. In many cases a visit within 14-days post discharge is a more appropriate target and better reflection of best practice.
The WFHT received an automated daily discharge report in Excel listing patient name, visit number, admit date/time, discharge date/time, PHN and admitting diagnosis. This criteria is used to identify patients admitted and discharged and help us immediately book a followup with patients with specific CMGs: Cardiac conditions other than heart attack, CHF, COPD, Pneumonia, Diabetes,Stroke, GastroIntestinal Disease
The team offers an intensive hospital discharge program. One that other FHT's in the region have also incorporated. The FHT's registered nurse access the local hospital's meditech system and runs a report of patient discharged that day. This is done because notification of discharge through a discharge summary is often not received in a timely manner. The RN will then make a follow-up discharge phone call within 3 days of discharge. The discharge phone call uses a standardized EMR entry form to capture data in a standardized format, while also provided best practices for discharge follow-up care. If deemed necessary, the family physician will provide follow-up care in a timely manner. This process helps to prevent unnecessary travelling and stress on the patient during this critical time. The RN insures that the patient is receiving the right care at the right time by the right provider. Based on the follow-up phone call the RN can help the patient navigate the health care system and insure continuity of care.
11 out of 82 physicians participated in the data collection process. Physicians sent the data collection sheet back to analyse the data. 82% of high risk patients were followed up within 7 days of discharge from the hospital.
FHT has access to Hospital Database, so there is a daily download of all the FHTs patients (who are recorded as such upon admission). These names are added to a spreadsheet which flags up those patients who are no longer on the hospital records (according to previous entries). The case manager goes through the list of those who have been discharged and checks available information (discharge summaries/scans) to see what has happened. If patient is not deceased, she will then make phone contact, and call them in or refer them to the pharmacist for a med rec. She will follow up with patients regardless of their condition, and phone calls are counted as a follow up. All of this is documented in the patients chart.
RNs receive hospital discharge reports twice weekly and follow-up with patients via telephone. Calls are tracked within the EMR via use of fake billing code. If the RN deems the patient needs to be seen, an appointment is scheduled. It is important to note that physicians typically discharge their own patients so those patients requiring in-office appointment for follow up within 7 days, physicians ensure those are booked with our reception.
The local hospital produces a report of all discharges for this team. Then the list is manually reviewed for the relevant discharges based on diagnosis.

Our performance (61%) reflects the percent of patients who saw their primary care provider within 14 days after discharge from hospital for all conditions. We believe that a 14 day measure was an important measurement as it aligns with billing practices among our physicians.
On a daily basis our RPN queries Hospital Discharge and runs the report. She then checks to see what the person was in the hospital for and if discharge notes that a follow up is necessary the task is sent to reception to book a follow up with the patient's primary care provider. If there is no mention of a follow up the primary care provider is sent a task enquiring if they would like to see patient and when and if so then a task is also sent to reception to book a follow up.
Varies between clinic - approach trying to standardize includes phone call within 48 hours from the office staff to flag concerns and ensure appointment booked, and follow-up appointment with one or a combination of the following: physician, chronic disease nurse, pharmacist.
The Markham FHT Transitions Program is about reaching inside current silos of care, becoming integral in the patients' transitions between health care settings and ultimately streamlining care for the individual, the family, and the health care system. The program achieves this by bringing primary care to the community hospital bedside, through a visit by the FHT registered nurse, who assists in the transition from hospital to home by arranging medication reconciliation, post- discharge follow-up, and other necessary care. This program is intent on future-proofing sound primary care team-based care - as the foundation of the health care system.
Reports are received through POI daily with ED visits and admissions. The hospital is contacted by our office to schedule a follow up appointment upon discharge if necessary. When discharge medications are received the patients are contacted by the pharmacist who follows up either by appointment or a phone call to review.
The Burlington Family Health Team (BFHT) endeavors to see patient's who have recently been discharged from hospital in a combination of ways, within 7 days of discharge including: Open access booking allowing patients to be seen same-day or next-day by their GP. House calls to frail, elderly patients who cannot access the clinic by the NP and/or OT via the BFHT Aging at Home program. All physicians at the BFHT have hospital privileges at the local, community hospital, and are often the most responsible physician (MRP) in hospital and can encourage patients to follow up in a timely manner following discharge. The BFHT has partnered with the local Health Links program, as well as the Integrated Comprehensive Care research program for intensive care planning and implementation of community supports following hospital discharge. This allows for more frequent monitoring of the patients' condition post-discharge through case conferencing and written updates with the interdisciplinary care team. The BFHT Quality Improvement Committee is also in the process of reviewing a method for statistically tracking the number of patients who have contact with any interdisciplinary health team member within 7 days of hospital discharge.
We are an HRM recipient. We have also developed an automated weekly EMR search for "all ER discharge reports received in the past 10 days"; the report is delivered to a pharmacist for review of potential medication adjustments. Providers may also request a phone call be made to a patient by an RN, to assess post-discharge needs & plan for follow-up.
1. Discharge summaries are attached to the patients charts and sent to provider inbox. In some cases the report is downloaded automatically to the provider's inbox via HRM. In some cases the discharge reports are received by mail or by fax. When this is the case, it is attached to the chart by an MOA and then placed into the provider's inbox. 2. Provider reviews documents 3. If warranted, the provider then tasks their MOA to call the patient and schedule a visit according to the doctor's instructions. They are usually specific in when they would like the visit to be booked. 4. When appointment is booked, follow up post hospital discharge is included in the appointment note. 5. The macro "hosp" is used if the patient is booked within 7 days of discharge from hospital
1) When notification received by provider (MD/NP) message sent to book follow-up 2) For select conditions hospital calls and books follow-up with provider (MD/NP) before discharge.
Each week, administrative staff pull lists of patients who have been recently discharged from Clinical Connect, a regional viewer. An RPN phones each patient to confirm their plan of care. All patients discharged receive a phone call; an in-clinic appointment is scheduled if needed.

Our team approach is to ensure our patients receive a follow-up visit within 7 days following hospitalization. We monitor the hospital discharge information through the new SHIIP portal. This portal is checked at least twice weekly and we record details about patient discharges in a tracking sheet. We reach out to the patient to book an appointment, if one has not been scheduled. When patient comes in for the visit we have a Hospital Follow up Visit Stamp that we use to capture data about the visit. Our tracking sheet contains patient demographic with unique identifier, hospital admission diagnosis, HIG criteria (formerly CMG), CCP patient, who booked f/u app, if f/u booked with specialist, details if discharge summary and update medication list were available at time of visit. Based on the results in our tracking sheet we are now analyzing to see what percentage of patients were seen and the number of days from discharge to appointment.
Our local hospital usually calls from the ward before the patient is discharged to book the appointment. We have just recently started using HRM - it was initially trialed by 3 providers and now that we are satisfied with the process we are bringing additional providers on board which should help with post-hospital follow up. This is our first year submitting to D2D and we unfortunately missed the deadline for accessing our primary care practice reports but we will have them in time for the next D2D submission.
when the report is received, it is reviewed by the nurse practitioner and the patient is called to book an appointment by the unit assistant within 7 days with their MRP.
Start with an EMR search for pts that have been discharged from hospital within the last quarter, using the discharge summary in the search. Then there is a manual review to see if they have been seen within 7 days of discharge.
The FHT has recently been afforded access to the local regional hospital's data base so as to obtain discharge information on our patients daily. The nurse is assessing the requirement to have a follow up appointment within 7 days, involving the physician if the need is not clear.
Physicians at the Thamesview Family Health Team round their own patients and are discharged by their physicians or physicians within their team. Patients currently are advised to book an appointment with front line staff through their discharging doctor. Front line are aware of the 7-10 day rule. We had a dedicated nurse working with all of our discharge patients and this has been eliminated due to Health Links and man power. The focus currently has been on high end users. We are reallocating our staff to again focus on all hospital discharges. We will be implementing all discharge patients have follow up phone calls.
Our doctor's are responsible for hospital discharge of their patients (if the doctor is unable to discharge their patient they receive a discharge notice through HRM within 24 hours). Followup is based on an individualized assessment for each patient.
Manually tracked by a nurse who reviews each discharge summary received, and then schedules an appointment for the patient if needed.
Although our in-house physicians have the ability to accommodate post-hospitalization appointments in a timely manner; discharge notification and/or summaries etc. are not being received by physicians or to the Family Health Team within the 48 hour timeframe therefore client post-hospitalization follow-up cannot be achieved as per definition. Currently, our organization is participating in a readmission project with our local community hospital. An element of this project is related to notification and scheduling of, medical related conditions, post hospitalization appointments with our in-house physicians. This has somewhat improved the scheduling aspect however these appointments lack the essential hospital documents e.g. discharge summaries, patient discharge plan etc. to ensure these appointments are valuable, meaningful and facilitate positive patient/physician outcomes.
From Health Analytics Branch Data Portal
The FHT has chosen to only focus on local hospitals discharges due to the timeliness of the electronic discharge notifications while for other hospitals, we still rely on paper faxes. The discharges are flagged from Monday-Wednesday (when Pharmacist in clinic) on Citrix/MediTech by Pharmacist and she informs the physicians and their admins to phone patients to book a follow-up appointment within 7 days of discharge. Only patients who were admitted with specific diagnoses get flagged, as determined by the Ministry. These discharges are recorded on an Excel spreadsheet, including date of discharge, date of call, and date of clinic visit. Reasons for untimely follow-up is also documented.

When our patients are released from the St. Marys Memorial Hospital, which is attached to our clinic, the RN's/doc schedules an appointment for appropriate f/u. If our patients are released from another hospital they are told when they need to be seen, after calling our office an appointment is arranged with in the time frame given.
We are currently developing a process for 7 day f/u after hospitalization
HRM connected Aug 2016, still working on process for f/u. Some MDs follow pts in hospital so don't need f/u in office. May have f/u with specialist or IHP or transfer elswhere.
Because the team is located in a rural small community, the FHT physicians are also the on-call and emergency department physicians at the local hospital. That means that all FHT patient's admitted to hospital are being cared for by a physician within the team. The FHT's aim is to provide hospital discharge follow-up in a timely manner while also insuring that they are being seen by the right provider at the right time. The FHT registered nurse will either make a follow-up discharge phone call or have the patient attend an appointment at the team within days of discharge. The FHT pharmacist will complete a mediation reconciliation if a medication list is forwarded upon discharge. If necessary the pharmacist will arrange an appointment with the patient to discuss their medication, however often times these are done over the phone to help avoid unnecessary travelling for the patient. The family physician also provides timely access for patient's recently discharged from hospital. When and if an appointment is required is determined when the physician discharges the patient from hospital. Information on how the EMR data was retrieved: Denominator: looking for discharge summary reports received January 1st or later Numerator: the search looked for 3 criteria occurring January 1st or later 1)appointment type used for hospital discharge appointments with the physician 2) the encounter assistant used by the RN for hospital discharge f/u phone calls 3) the encounter assistant used by the pharmacist to record medication reconciliation post discharge Not that both the numerator and denominator provide the number of patients and not the number of discharges. Therefore patients with a readmission within that time period are only counted once.
Toolbar and encounter assistant in place for tracking. Hospital reports received through HRM. Reception enters data in EMR. Nurse dedicates time each day to call discharged patients and documents phone encounter with a stamp. Patients are seen in person if needed by IHP or MD as appropriate.
Still in the data collection stage from local hospital. Started receiving manual reports that ID our patient's discharges.
Each morning QIP Staff checks Clinical Connect Discharged Patients Source = HHS /Facilities = All /Days Back = 3 /per physician Repeat this process for Source = NHS/All/3 days/each doc If patient appears on the list then click on their name to see date of discharge Check EMR to see if patient has an appointment booked to see their physician If patient has been discharged and has no appointment booked then: Choose discharge on the toolbar and follow through to complete the drop downs Click finish and then the note will be stamped in the chart Send a message to receptionist to book within 7 days Recep'n adds comment to appointment line stating f/u to hosp Once apt is booked select appointment from the toolbar and follow through to complete the drop downs The note will include a highlighted message to the physician to remind him/her to bill the E080 at that visit patient attends for apt
Each day, we receive a list of patients who were discharged from our hospital the previous day. We track which received either a phone call or a home/office visit with an MD or NP within 7 days post-discharge. This figure includes only patients discharged from a medical service.
Our FHT utilizes the CKHA Portal to schedule an appointment with the patient's primary care provider and/or our IHPs for timely post-hospital follow-up. Two administrative support staff have been assigned to daily go into the CKHA Portal to check if any of our patients are in hospital. Once the patient is discharge from hospital, the admin staff contacts the patient to schedule a post-hospital discharge follow-up appointment. The appointment is marked hospital discharge in our EMR. Hospital discharge information is also entered into a detailed excel spreadsheet in order to track timely information about post-hospital follow-up and readmissions.
We do not currently have a method of measuring this. The expectation is that SHIIP will allow us to accurately measure this indicator in the future.

The primary providers (MDs & NP) send a message to CDRN whenever they receive a qualifying discharge summary. Using a custom form in our EMR, our CDRN tracks data related to follow up of the discharge, including if the patient was contacted within 7 days of discharge or not. A query is used to pull data for the CF on a monthly basis, and that data is reported back to the team. Our measure is % of patients with qualifying discharge that were contacted within 7 days of discharge. Started tracking data in July 2015, so reported rate for D2D 4.0 includes data from July 2015 to July 2016 inclusive (80/97 = 82.47%).
We are currently in a joint project with the Listowel Memorial Hospital where appointments are booked for patients on hospital discharge by hospital staff into our primary care EMR. Sufficient data from this project is not available at the time of the D2D submission.
Local hospital faxes discharges the day after the discharge. Weekly emr search for other hospital discharges. Booking clerk calls pt to set up post discharge appointment if not already booked.
Each day we receive a discharge report from a major local hospital. An EA is entered in to the patient's chart and a message is sent to a nurse. Each patient that is discharged home is contacted by a nurse for follow up. If an appointment with a physician is required, one will be booked. The nurse will enter another EA in the chart to track outcome of the followup call.
Local hospital call and book a follow-up appointment before discharging patient.
Similar to PODS we have a paper discharge followup tool on the chart that is faxed to the fht upon discharge. is supposed to trigger an appointment within 7 days but is not making any difference as of yet (6 months running)
Similar to PODS we have a paper tool in the chart at the hospital. This gets faxed to the fht on discharge and is suppposed to trigger a followup appointment and a med rec. The med rec success is close to 100% successful while followup has not changed.
RN at two of three sites ensures follow up appointment with Physician or FHT provider within 7 days of discharge when appropriate. In some cases a visit within 14-days post discharge is a more appropriate target and better reflection of best practice "
We have created an internal spread sheet to track post-hospital discharges. Once the physician receives a hospital discharge summary in his/her Lab In-Box from Hospital Report Manager, an urgent message is sent to the front staff. The front staff then calls patient that same day to book an appointment within 7 days post-discharge. The patient is called until they are reached and a follow up appointment is made with their physician. This appointment is colour coded in the EMR. If the patient is a no show for their appointment, the patient is called by the front staff to ascertain the rationale for missing the appointment and to re-book this appointment to see their physician.
Discharge notices are received. Physicians identify who needs to be seen in-office. All patients with the exception of OB patients, patients transferred to another inpt facility, & those being seen in-office or home visit within 48 hours post-discharge) receive a call from an RN within 7 days post-discharge. Our RNs reach 84% of patients, with average number of days post-discharge=4. We do not count weekends or statutory holidays.
The BFHT Quality Improvement Committee are developing a process for team members, other than physicians, to track patients who are seen or contacted within 7 days post hospital discharge. We look to include any IHP's as well as nurses in this process whether it be by phone or in person.
Weekly screening for discharge reports preformed by pharmacist, HRM recipient, Provider phone call to assess discharge needs & plan for f/up
Our hospital discharge program provides patient's discharged from hospital with a team based approach and ensures the patient is being seen by the right provider at the right time. Our family physician's have an extensive on-call schedule to ensure that FHT patients admitted under Family Medicine are being cared for and followed by a physician from the FHT. When the FHT physician discharges a patient, they call the team to arrange an appointment with their primary care provider within 10 days. During this call the nurse is sent a message notifying her of the discharge. If required, the pharmacist is also notified. The patient leaves the hospital with a follow-up appointment date with their family physician. The FHT nurse does an extensive follow-up discharge phone call within 48 hours of discharge. The pharmacist will complete a medication review (if required) either by phone or in-person within 1 week of discharge. Data Tracking: Appointments with the health care provider are tracked using an appointment type in the EMR. When the RN does a follow-up discharge phone call, she uses an encounter assistant that not only tracks if the phone call was completed by when, important information about the discharge, if the discharge summary was received, etc. The pharmacist also uses a detailed encounter assistant to track the medication review,

this encounter assistant tracks any medication related problems that were adverted due to timely follow-up. Next steps: Patient's discharged from other specialites are also included in this successful program. However, receiving timely notification of discharge is critical to their enrollment in the program. Team members have been working with the local hospital to receive better and timely notification of discharges. A physician has enrolled in HRM for e-notifications to help to capture these patient's however no local hospitals are using HRM technology. Overall, this program has alot of success. The same procedure and EMR tools are being used by other FHT's in this region with equal success. Please note: that searching for hospital discharges within the EMR is a difficult task. We are unable to determine if the hopsital discharge summary report was received in a timely manner, often times reports especially for patient's discharged from a speciality other then family medicine is received outside of the optimal follow-up period. Therefore, it is expected that our performance to be much higher then reported. In addition, the EMR can only produce the number of patients with a hospital discharge follow up, it does not provide us with the number of hospital discharges - therefore eliminating any re-admission information.
Lists of all patients discharged are pulled weekly using the regional viewer, Clinical Connect. All discharged patients receive a telephone call from an RPN, and an in-clinic appointment is scheduled when needed and based on patient preference. 74.3% of patients are contacted within 7 days of discharge; 100% within 14 days.
I received access to a local regional hospital's data base to assess discharges, patient admissions and ER visits for our patients. Starting small, we message the physician of a patient discharged with a diagnosis of CHF or directly call the patient to make an appointment. This is done daily Monday to Friday (Monday includes Saturday and Sunday as well). We are progressing to an additional diagnosis of COPD now that this process is well established.
With the ability of our in-house physicians to now access their patients' hospital admission and discharge information via computer and in conjunction with their continued ability to accommodate post-hospitalization appointments in a timely manner, we are confident our hospitalized patients, especially those with specific health and chronic conditions, are being referred and scheduled for more timely and patient-centred post-discharge appointments. In regard to our participation in the readmission project with our local community hospital; the number of these post-discharge appointment referrals has significantly dwindled in past months. However; it is evident our communication and patient education efforts appear to be yielding some success as the number of patients calling directly to schedule a post-discharge appointment has increased as has the number of referrals from our in-house physicians to schedule this type of follow-up appointments. Our plan is to continue to monitor, evaluate and improve, if identified, our post-discharge follow-up efforts, from a timely and patient-centred perspective, in the upcoming fiscal year.
47% is the portal indicator. As a process measure, BQWFHT is tracking the number of patients discharged for any reason who receive a post-discharge appointment within 10 business days (two weeks). These data are reconciled with billing data for E080 (billing code for first post discharge visit within two weeks). Our process measure shows that 79.4% of patients hospitalized for any reason were seen 2 weeks post discharge.
This is from the Health Data Branch number. Our team has started a Post Hospital Discharge Medication Reconciliation program. This program just recently started, it will have a data collection form that we will use for the next entry.
this number is for one physician only as our EMR is NOD. We have developed a new process with that physician's office for use of the LENS (her hospital report) and Nightingale for charting and reporting purposes.
HRM connected Aug 2016, still working on process for f/u. Some MDs follow pts in hospital so don't need f/u in office. May have f/u with specialist or IHP or transfer elswhere.
Current procedure - PT d/c from regional hospital - FHT physician notified by discharge dr. message sent via EMR to reception to book 7 days post discharge. Pt d/c from other hospitals receive d/c summary via HRM, reception to book f/u apt with pt.
Our nurse reviews all the discharge notifications for patients released from OTMH and on HRM. Our nurse then calls each patient to see if follow up with their primary care provider is required. If not, then a consultation is done with the nurse via phone or an appointment is made with the appropriate health care provider.
***WE RECEIVE A DAILY INPATIENT DISCHARGE REPORT FROM THE HOSPITAL REPORT IS REVIEWEDBY RN DAILY AND A TELEPHONE FOLLOW UP IS PROVIDED TO PATIENT IF APPROPRIATE. FOLLOW UP IS DOCUMENTED IN THE EMR ***ALL PHYSICIANS ARRANGE FOLLOW APPOINTMENT WITHIN 14 DAYS WITH PATIENTS DISCHARGED FROM HOSPITAL IF APPROPRIATE. NEW BORNS WITHIN 24 HOURS

*** SOME PHYSICIANS SEE OWN PATIENTS IN HOSPITAL AND WILL ARRANGE FOR FOLLOW UP AS PART OF PATIENTS DISCHARGE INSTRUCTIONS
We receive data from our hospital each day about patients who are discharged. We report the percent of patients, who are discharged from a medical service to their home, shelter, or unknown location, who are seen in person within 7 days post-discharge by an nurse practitioner or physician. Moving forward, we are planning to track phone calls and email contact from all clinicians as follow-up.
Our FHT utilizes the CKHA Portal to schedule an appointment with the patient's primary care provider and/or our IHPs for timely post-hospital follow-up. Two administrative support staff have been assigned to daily go into the CKHA Portal to check if any of our patients are in hospital. Once the patient is discharged from hospital, the admin staff contacts the patient to schedule a post-hospital discharge follow-up appointment. The appointment is marked hospital discharge in our EMR. Hospital discharge information is also entered into a detailed excel spreadsheet in order to track timely information about post-hospital follow-up and readmissions. Providers are also receiving eNotification reports and messaging the reception staff to book an appointment. We also want to look at patients discharged from other hospitals in our area (WRH, LDMH, BWH).
Our local hospital faxes the daily discharge list. An emr search locates discharge summaries from other facilities. A clerical person checks to see if the patient has already booked an appt. If not, we have just started a pilot project; a nurse calls the pt to assess whether an appt with a MD or NP is needed, and if so, an in-office or phone appt. If an appt is necessary, the nurses messages the booking clerk to book appt.
Each day we receive discharge reports via HRM. A message is sent to a nurse who contacts each patient discharged home for a follow up. If an appointment with a physician is required, one will be booked.
Our discharge process is as follows: -Discharge papers are sent to our FHT from the local hospital -They are copied to our EMR, into the patients chart --The nurse messages the admin staff to keep track.

Change ideas from QIP reports (as reported in Navigator)

Change Ideas	Methods	Process measures
Corporation Of The Municipality Of Assiginack: Discharge Planner within our FHT	We have appointed a point person in our FHT and when any patient is discharged from the local hospital the information or a phone call is given to that person. Our RN is the person that calls the patient and either books the appointment or discusses the discharge.	Number of patients discharged from local hospital Number of patients discharged from off island hospital Number of patients seen within 7 days of discharge
Dilico FHT: Work with the Dilico Home and Community Care Discharge Planners	Identify and flag patients in hospital. The Discharge Planners work at both the complex and acute care centers within Thunder Bay and are able to identify clients prior to discharge.A client encounter form will be developed which will automatically notify the FHT Social Worker of a discharge and that follow-up is required. The form will forward relevant information to the Social Worker so an appropriate appointment can be scheduled or information provided	Evaluate the number of clients being discharged from Acute/Complex care hospitals with the number of follow-up appointments scheduled within 7 days. Track rostered clients in hospital and monitor progress and follow-up with primary care team.
Leeds and Grenville FHT: To improve utilization of EMR appointment type codes for post-hospital discharge patients.	1. Remind primary care providers to select the 'post-discharge' appointment type, where appropriate. 2. Target follow-up appointment calls to patients discharged from hospital 3. Results to be reviewed by Quality Committee to ensure appointment type being used. 4. Results to be given to providers and reviewed.	Number of providers that select post-discharge appointment type Number of appointment type codes

Niagara Medical Group FHT: Working with CCAC/LHIN and the Niagara Health System to track our discharged patients	With the development of our Care Navigation program we are working with CCAC/LHIN and the Niagara Health System to track our discharged patients so that we can have immediate contact post discharge and initiate care plans and contact with patient's within 7 days of discharge. We are meeting with CCAC/LHIN, The Niagara Health System discharge planners. Having pre-set care plans based on disease and complexity for our care navigator. Tracking and contact patient's post hospital discharge Creating accessible appointments specifically for post discharge patients	Tracking the number of patients that have received care 7 days post discharge. Tracking appointments used within the allocated appointment times for the post discharge patients.
Northeastern Manitoulin FHT: Processes to notify primary care provider when patient is discharged from hospital	1) We receive discharge notification from hospital within 24 hours of discharge. 2)The Hospital staff call the clinic and book the follow up appointment,. 3) We code the follow up visits as Hospital discharge follow-up appointment type in the EMR 4) Our RPN's review the daily LACE tool sheet provided by the Hospital and document the follow up visit date or book a follow up visit	1)Manitoulin Island Collaborative Discharge working group will monitor and review data. 2)Number of family health team patients with discharge notification sent to primary care provider.
Sunset Country FHT: Work with FHN physicians to create process for using discharge report	Board/Lead physician to draft pathway, in partnership with hospital, for post discharge appointment scheduling.	Pathway to be created and implemented.
Temagami FHT: Use IHP stats encounter assistant for data collection	A check box for follow up within 7 days post discharge from hospital was added to our IHP stats encounter assistant for ease of collection and reporting by all providers.	# of 7 day follow up appointments, # of home visits post 7 day discharge, # of phone call follow ups post 7 day discharge
Thamesview FHT: Use HARP screening tool for patients who are discharged	Ensure 7 day follow-up with physician has been scheduled. Track hospital discharge follow-up with other care providers.RN will obtain list of patients discharged from hospital and will complete HARP screening tool on patients to determine risk of readmission. (Exclusion criteria: admission involving patients <18 y.o., OB related, psychiatric admissions, elective surgery and discharge to hospice care.) Phone calls are being completed on patients without appointments booked within 7 days (minus the exclusions).	1)Percentage of patients discharged who were re-admitted to hospital within 30 days. 2) Percentage of patients discharged who were followed-up within 7 days and re-admitted to hospital within 30 days. 3) Percentage of patients discharged who were not followed up within 7 days and re-admitted to hospital within 30 days.
Wawa FHT: Coordinate with Ontario MD to sign up to e-notifications	Arrange meeting with Physician to explain benefits of e-notifications and receiving info. about their discharged patients from other hospitals in general. Then, have one of the Physician sign up for the initiative as a pilot project.	Number of Physicians sign-up to HRM e-notifications and receiving them.