Implementing Primary Care Follow-up for Vascular Surgery Patients

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Problem Statement

- Since 2013, hospital Medicare reimbursement has been linked to hospital performance and quality of care.
- Hospitals are required to report their 30-day readmission rate linking payment to the quality of hospital care, encouraging hospitals to develop strategies to improve communication and care coordination to engage patients and caregivers in discharge plans to reduce avoidable readmissions.
- In a large urban academic medical center, the 30-day hospital readmission rate for the fiscal year of 2020-2021 was 17.5%, which is above the department target of 13.5% and national average for vascular surgery of 11.9%.
- One method to reduce readmissions and provide care continuity is to have a patient visit a primary care provider within two weeks of discharge.

Purpose of Project/Goals

Purpose

- The purpose of this quality improvement initiative was to target vascular surgery patients who are at high risk for readmission and arrange a primary care provider (PCP) follow-up appointment within two weeks of hospital discharge.

Goals

- 100% of vascular surgery patients will be screened utilizing the "HOSPITAL" tool and categorized as either high-risk or low-risk for readmission.
- 100% of the vascular surgery patients categorized as high-risk for readmission will be arranged for PCP follow-up within 2 weeks of their hospital discharge.

Methods

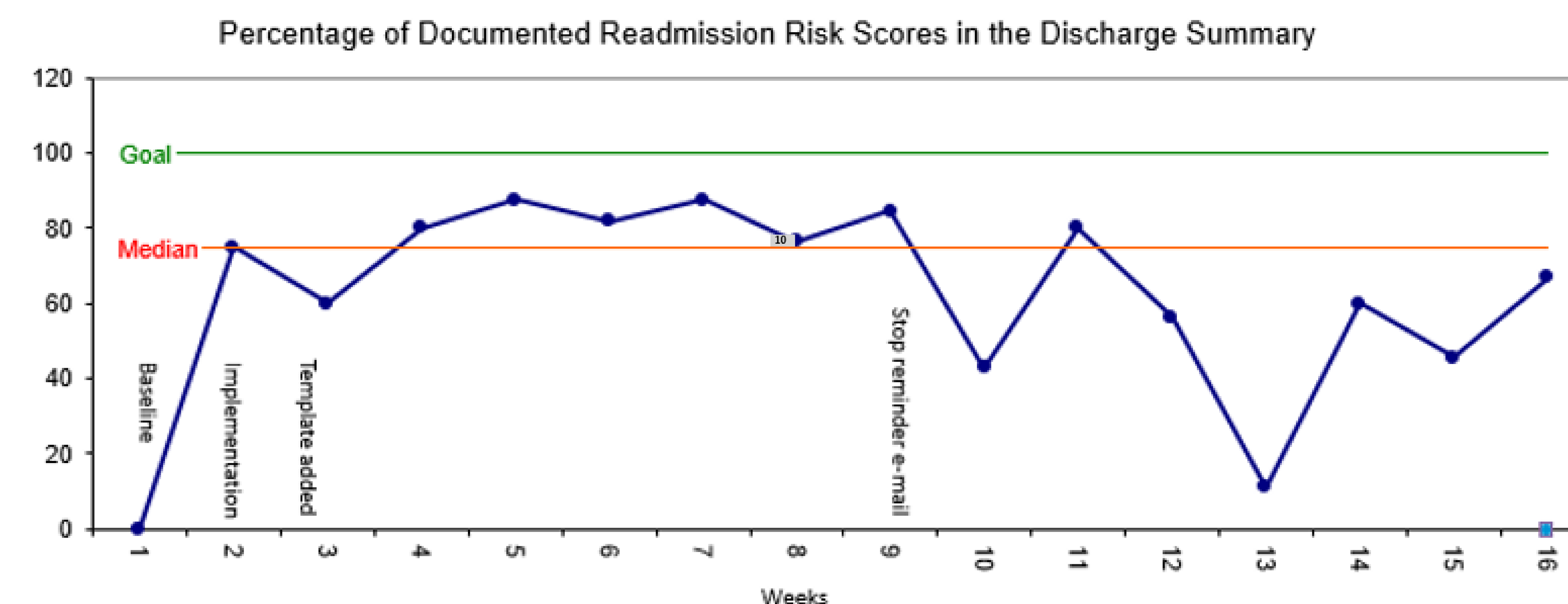
- **Setting:** Department of Vascular Surgery at large Urban Medical Center
- **Population**
  - *Target:* Vascular surgery discharging providers including 11 nurse practitioners and 6 residents.
  - *Patient:* Included vascular surgery patients discharged to home. Excluded patients discharged to acute or subacute rehabilitation, transferred to another service or expired.
- **Duration:** 15-week period during fall/winter of 2022.
- **Intervention**
  - Discharging provider utilized the "HOSPITAL score for Readmission" validated tool to identify patients categorized at high-risk for an unplanned 30-day readmission and ensured follow-up appointments with a PCP.
  - For identified patients without an established PCP or whose PCP could not accommodate an appointment, a hospital-based transitional care clinic appointment bridged medical care until PCP establishment or resumption of care respectively.

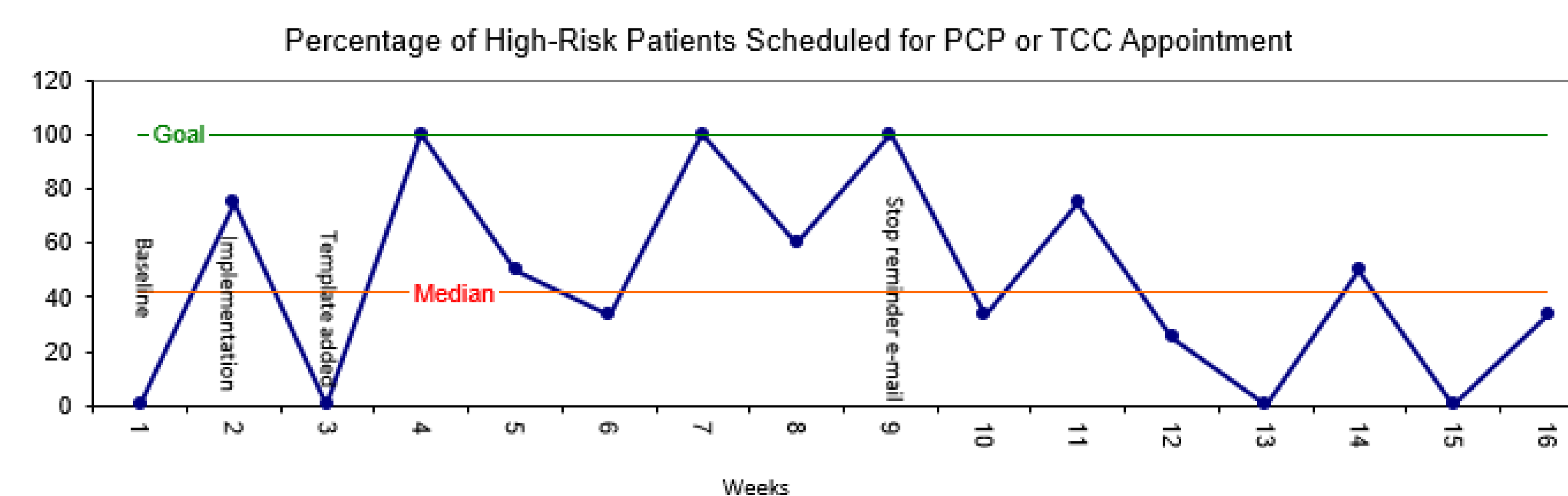
Hospital Score Tool

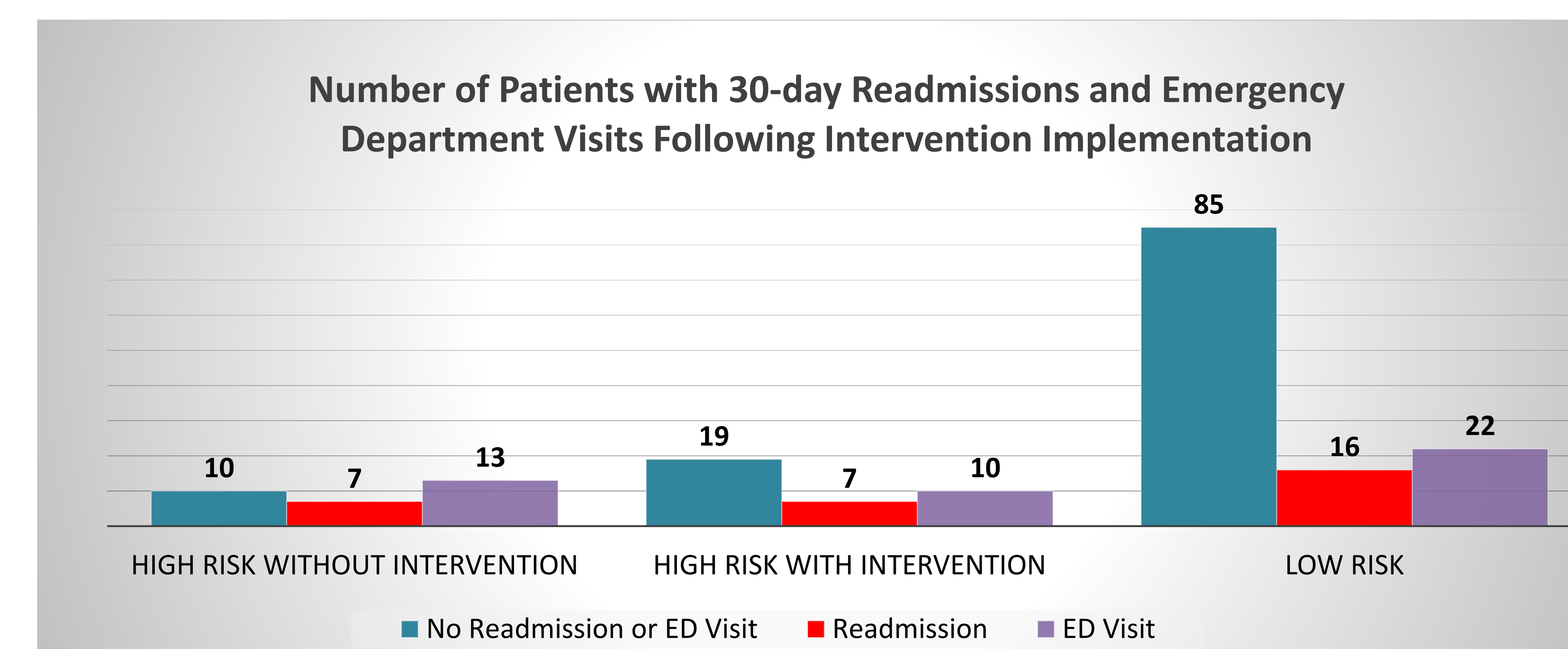
Methods Continued

- **Implementation Strategies**
  - Collaboration: Identified early adopters and champions to help encourage others to be consistent towards compliance.
  - Communication: One on one discussions with discharging providers and weekly e-mails to encourage compliance. Network weaving to involve transitional care clinic (TCC) for patients without an established PCP.
  - Technology: Creation of template within electronic health record for process standardization.
- **Measures**
  - Percentage of documented readmission risk scores in the discharge summary
  - Percentage of high-risk patients scheduled for a PCP or TCC appointment
  - Percentage of patients with an emergency department visit within 30 days of discharge
  - Percentage of patients with an unplanned hospital readmission within 30 days of discharge
  - Percentage of high-risk patients who attended their scheduled PCP or TCC appointment

Results/Figures







Results

- 158 vascular patients were discharged to home over 15 weeks
- Maximum compliance of recording the HOSPITAL score for readmission occurred during week 6 with 87.5%
- Maximum compliance of scheduling high-risk patients for PCP or TCC follow-up within 2 weeks of their hospital discharge occurred during weeks 3, 6 and 8 with 100%
- 30 patients (19%) had an unplanned readmission within 30-days
- 45 patients (28.5%) had an ED visit within 30-days
- 29 high-risk patients were successfully arranged for PCP or TCC provider follow-up within 2 weeks of hospital discharge
- Readmission rate for high-risk patients who received the intervention was lower (24.1%) than high-risk patients who did not receive the intervention (30.4%)

Discussion

- The goal of 100% of vascular surgery patients will be screened utilizing the "HOSPITAL" tool and categorized as either high-risk or low-risk for readmission was not achieved.
- Discharging providers were more likely to be compliant with the process change after creation of a template during week 3 within the electronic health record for process standardization.
- The goal of 100% of the vascular surgery patients categorized as high-risk for readmission will be arranged for PCP follow-up within 2 weeks of their hospital discharge was achieved.
- Discharging providers indicated a heightened awareness of readmission risk stratification regardless of the "HOSPITAL" score.

Limitations

- The initial surgical residents who received the implementation education rotated at various times during the project with residents who did not receive the education, which likely affected the compliance rates of the intervention.
- The weekly reminder e-mail to encourage participants to calculate the readmission risk score was stopped after 9 weeks, which likely affected the compliance rates of the intervention.

Conclusions

- A review of the PCP/TCC visits indicated medical management of various chronic conditions (HTN, anemia, depression) and acute conditions (hypotension, pain, UTI), which may have contributed to the lower readmission rate for this group.
- Increased usage of the transitional care clinic identified a gap that patients continue to require assistance with establishing care with a PCP; further process change in the future is needed to ensure successful transition for all patients.

References/Acknowledgements

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