Follow Up Appointment
Menu of Improvement Ideas

Upstream approaches

- **Hospital focused:**
  - Schedule the appointment within 1 day of admission to reduce lag.
  - For elective surgical cases, schedule the follow up at pre-op appointment.
  - Notify the PCP when the patient visits the ED or is admitted. Send a D/C summary within 3 days.

- **Patient Focused**
  - Ask upon admission “what physician would you like us to schedule your follow up with?”
  - Staff schedules the appointment the day before discharge to allow for family coordination of transportation and caregiver availability.
  - Provide all appointment information including phone numbers to change an appointment and secure transportation.
  - Prioritize for the patient and family, which specialist appointments are most important, if there are many.

Improve logistics for better access

- Target a specific patient population for timely follow up appointments.
- Assign responsibility based upon complexity. Case manager schedules follow ups for complex patients.
- Establish a system for the hospital to secure appointments during lunchtime, evenings, and weekends.
- Staff schedules the appointment with the patient in the room.
- Provide the patient with a number to call if they have any questions or problems before their follow up appointment. Contact must have access to medical record.

Care Coordination

- Schedule a brief huddle to review discharges (hospitalists, case manager, nurse, rehab, pharmacy, central scheduling, patient family caregiver)
- Find out and track time to next appointment by specialty.

Clinic / PCP Partnership

- Establish a shared goal for timeliness of follow up appointments for patients discharged from the hospital.
- Use a LACE score or other means to prioritize timely appointments.
- Clinic establishes system to triage discharged patients for timely appointments.

Working towards bigger change ideas

- Post Discharge Clinic that manages the patient until they can get in to see their primary care provider. Start with a specific diagnosis: Sepsis. CHF, COPD, COVID, PN, AMI
- Transitional Care Management services for Medicare Fee for Service Patients. Within 30 days moderate to high complexity patients must have an interactive contact (D/C call), a non-interactive contact (care coordination, med rec, education) and a face-to-face provider visit (f/u appt) CMS: TCM Services
- Create non-medical follow up services to meet social health needs.
- Patient resource specialist available 7 days a week, 8 hours a day for scheduling follow up appointments.

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