Implementation of a Clinical Pharmacy Specialist-Managed Telephonic Hospital Discharge Follow-Up Program in a Patient-Centered Medical Home

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Purpose

• To determine impact
• To examine feasibility of and characteristics that define an intervention and its outcomes as a best practice

Introduction

Health-Care Facility

• Integrated health system comprised of
  • Academic, level 1 trauma center
  • Network of community health centers, one of which is Eastside Adult Internal Medicine Clinic
  • Located in historic Five Points neighborhood in Denver

Experience with the Program

• Each call was individualized, but in general consisted of
  • Hospital course
  • Medication education
  • Discussion of discharge information
  • Appointment reminders and scheduling

Description of the Program

• Telephonic discharge follow-up was performed by two CPSs
• CPSs had access to patients’ electronic health records (EHR) and had a working relationship with patients’ primary care providers
• CPSs received daily list of previous day’s discharges from the safety-net hospital
• Each discharged patient’s chart was reviewed for net hospital readmissions
• CPSs had access to patients’ electronic health records (EHR)
• Telephonic discharge follow-up was performed by two CPSs

Experience with the Program

• Initiative included adult patients
• Discharged from safety-net hospital between July 1, 2010 and June 30, 2011
• Enrolled in PCMH

Characteristics of the index hospitalization

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Intervention (n=207)</th>
<th>No intervention (n=263)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital services N (%)</td>
<td></td>
<td></td>
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<tr>
<td>General medicine</td>
<td>116 (94.1)</td>
<td>124 (99)</td>
<td>0.20</td>
</tr>
<tr>
<td>Surgery</td>
<td>24 (16.5)</td>
<td>18 (6.8)</td>
<td></td>
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<tr>
<td>Other</td>
<td>9 (6.3)</td>
<td>11 (4.2)</td>
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<tr>
<td>Length of stay (days)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Median (IQR)</td>
<td>2 (1, 4)</td>
<td>2 (1, 4)</td>
<td>0.24</td>
</tr>
<tr>
<td>≤ 6 days N (%)</td>
<td>187 (93.0)</td>
<td>233 (88.6)</td>
<td>0.24</td>
</tr>
<tr>
<td>Scheduled follow-up appointments at discharge N (%)</td>
<td>144 (89.7)</td>
<td>155 (58.9)</td>
<td>0.02</td>
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</tbody>
</table>

Discussion/Conclusion

• Our intervention and its outcomes serve as a best practice
• Because of the positive clinical and financial impact of this type of intervention, institutions should consider allocating resources for post-hospital discharge follow-up services that include CPSs
• Our intervention and its outcomes serve as a best practice model for other institutions actively engaged in improving transitions of care

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Authors have nothing to disclose.