Transitional Care Management

Myrtue Medical Center Rural Health Clinics

Kim Burchett RN, BSN Clinic Administrator
Harlan, IA

Objective

Increase the volume of patients attending a post discharge follow up appointment with their Primary Care Provider.

Background

Patients were not always attending post hospitalization follow up appointments for the following reasons:

Feeling better
Too busy
No time that coordinated with them
Lack of education of purpose of the follow up visit by nurses and providers
Inconsistency with dismissal phone calls
Inconsistency with follow up appointments made @ dismissal

Metrics

Prior to January 2018, 0% of hospital dismissals were contacted and scheduled for follow up by clinic Health Coaches. Currently, 100% of hospital dismissals are contacted and scheduled for follow up by clinic Health Coaches.

Analysis

Number of follow up appointments increased with the change of health coaches managing program.
Consistency with dismissal review; Only 2 nurses making the calls and providing education.
Direct communication with Primary Care Providers.

Actions Taken

Patient Education/Engagement.
Practitioner Education.
Make appointments prior to discharge.
Daily review of dismissals by Health Coaches.
Health coaches contact patients within 2 days of dismissal.
Messages to providers with concerns and reminders of TCM appointments.

Next Steps

Continue to work towards contacting all dismissed patients to schedule a follow up appointment @ 7, 14 or 30 days post discharge.

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