From acute care to primary care: examining follow-up with physician after acute care hospital discharge in Alberta and Saskatchewan

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Background

- Continuity of care as policy priority
- Improved continuity of care has many benefits
  - fewer medical errors
  - higher patient compliance to medical instruction
  - less complications after discharge
  - improved communication between care providers
  - the translation of health knowledge into actions at home

Background

- The post-discharge period can potentially be high risk and a vulnerable transition point for some patients.
- Best practices recommend that the patients discharged from acute care hospital should see a doctor for follow-up shortly after discharge.
  - chromic obstructive pulmonary disease (COPD): 1-2 weeks
  - heart failure(HF): within 2 to 4 weeks
  - acute myocardial infarction(AMI): within 1 months
- The study on follow up after acute care discharge is limited in Canada.

Study Objectives

- To determine rates of physician follow-up with a primary care physician or specialist after discharge from an acute care hospital;
- To examine physician-, patient- and hospital-related factors affecting physician follow-up;
- To explore the regional variation of physician follow-up rate.

Methodology (1)

Data sources:

2010-11 to 2012-2013

Discharge Abstract Database (DAD): index hospitalization

National Physician Database (NPDB): follow up

Pilot project in Alberta and Saskatchewan

Population:

- The patient was 18 or older with a most responsible diagnosis of AMI, HF or COPD
- The patients staying in hospital between 1 and 30 days
- Restricted to patients discharged to home or home with care
- Only select first admission for each patients--not preceded by a previous hospitalization 30 days prior

Methodology (2)

Follow up:

- Primary health care or specialist visit within 7/30 days of acute care discharge
- Identified based on fee code covering discussion of care, physician examination or patient assessment
- Both fee-for-service and alternative payments
- Include visits in clinics outside of hospital and within a hospital

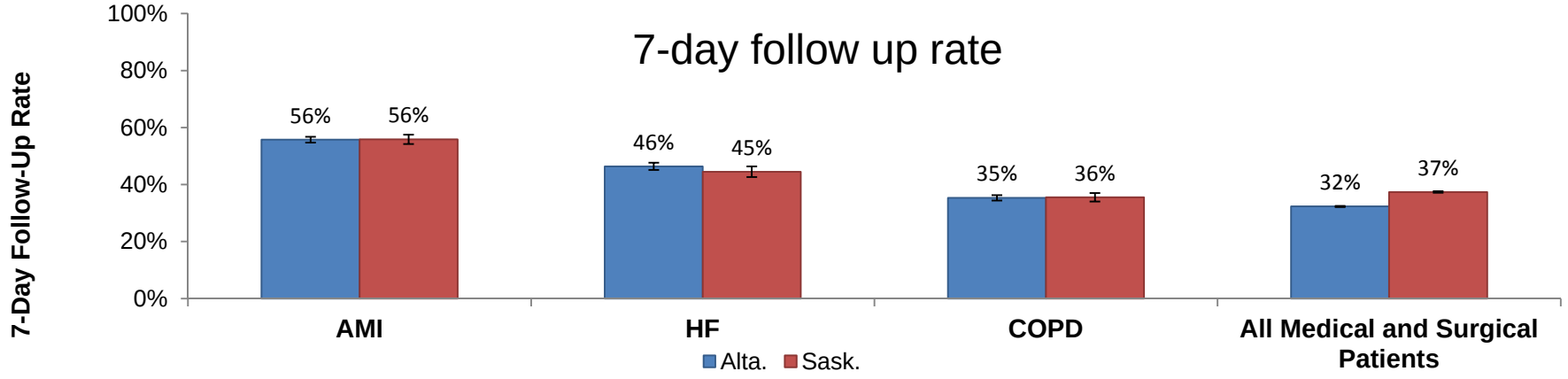
Familiar physician:

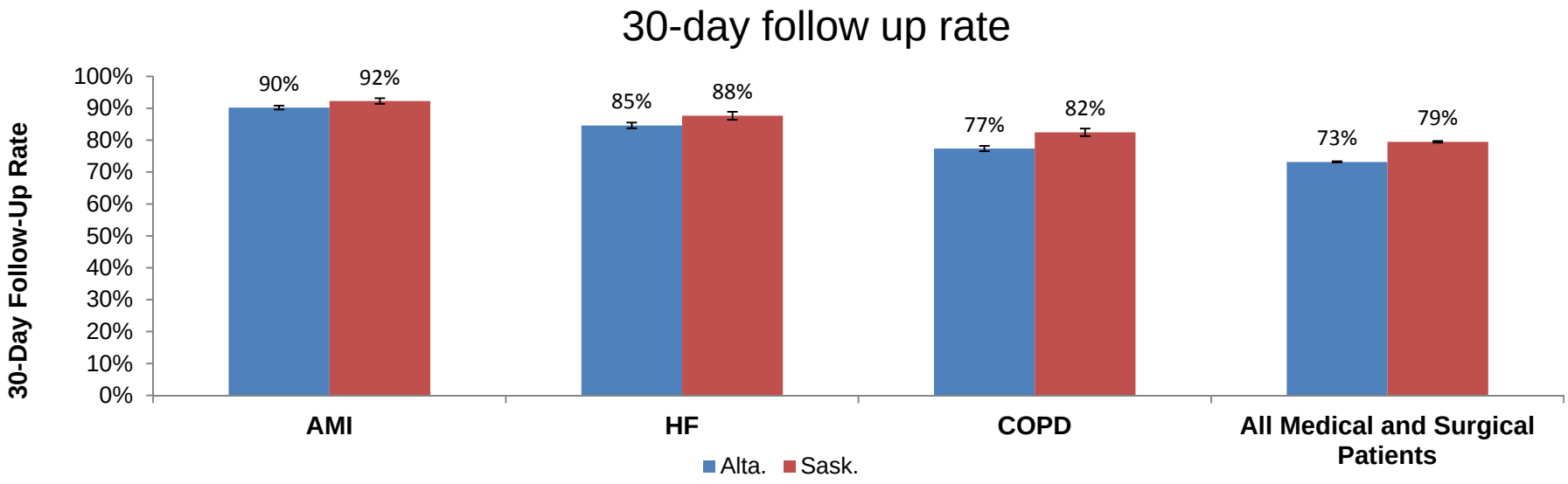
- Familiar community physician: A physician the patient had seen at least twice prior to the hospitalization within 1 year.
- Familiar hospital physician: A physician the patient had seen during the hospital stay.

Number of hospitalizations and unique patients, Alberta and Saskatchewan, 2010-2011 to 2012-2013

	AMI		HF		COPD	
	AB	SK	AB	SK	AB	SK
Index Hospitalizations	8,616	3,416	5,684	2,523	9,519	3,710

Most patients saw a physician within a month after discharge. Fewer patients had a follow up within 7 days.



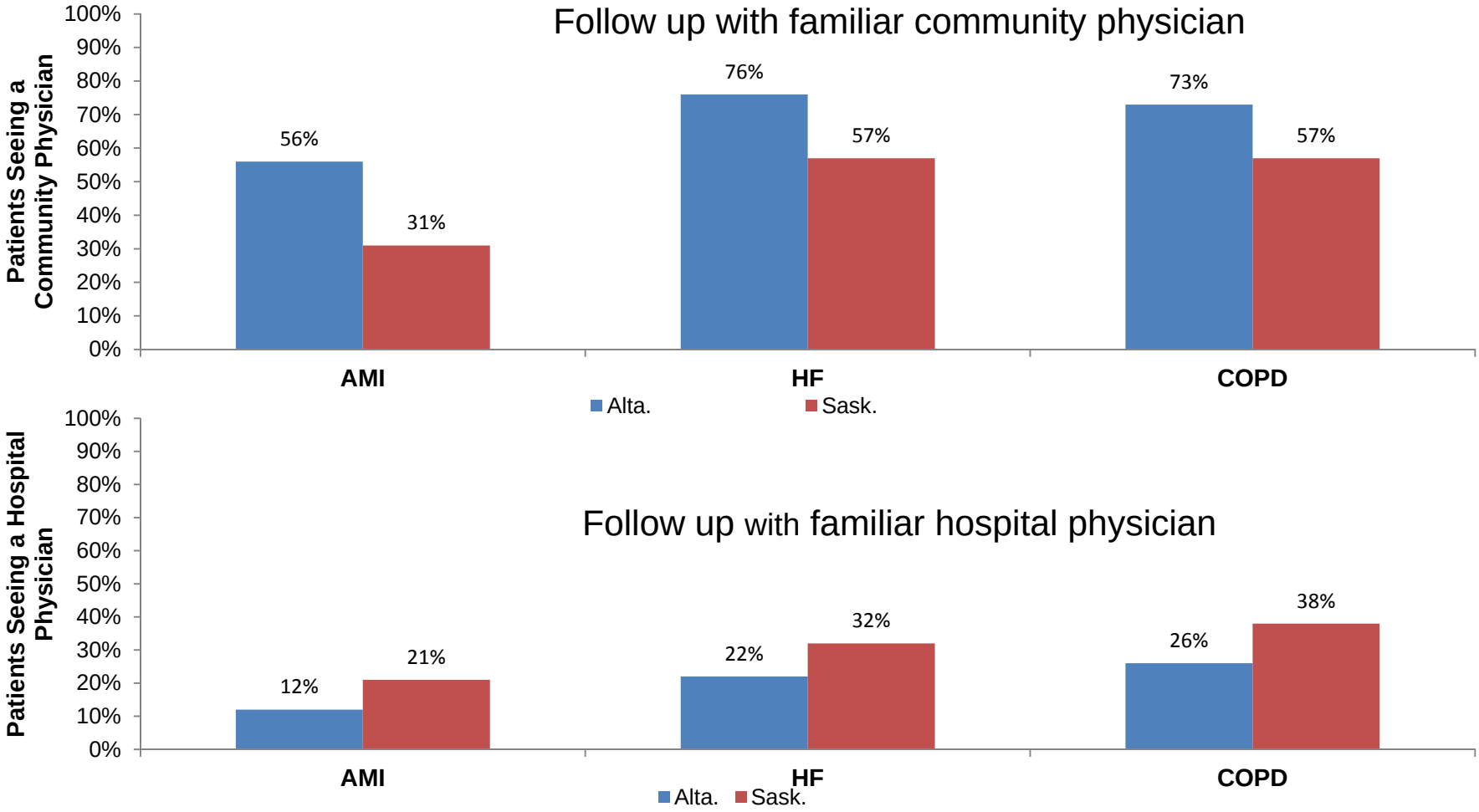


There was variation in follow-up rates

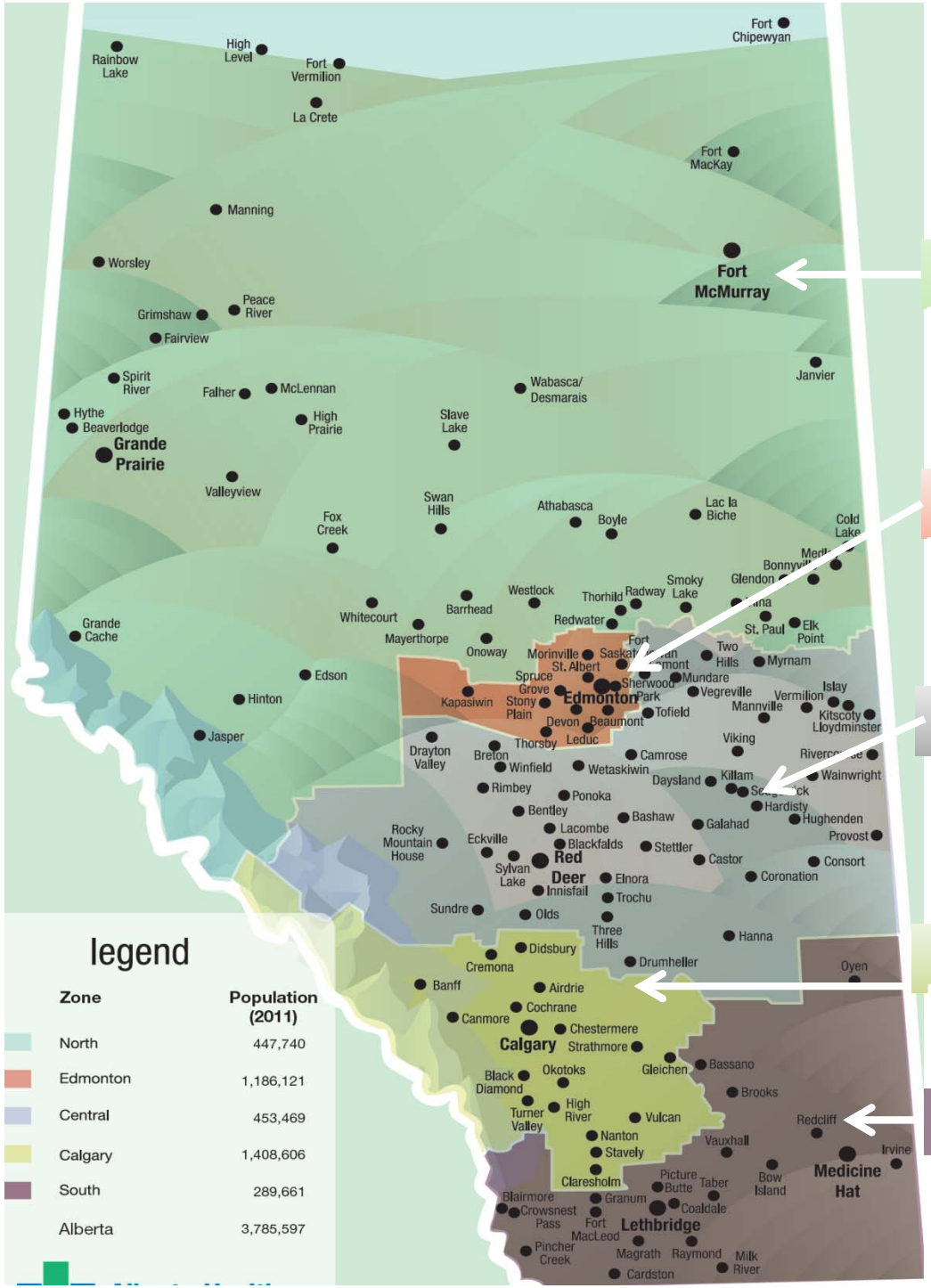
Lower follow-up rates were seen in patients who

- Lived in lower-income neighbourhoods;
- Lived in rural areas;
- Were discharged home with support services;
- Were discharged from community hospitals (versus teaching hospitals); and
- Didn’t have a familiar community physician.

Most 7-day follow-up visits were made with a familiar physician (AB: 75% vs. SK: 60%).



7-day follow up rate by region in Alberta



North: 450,000 people

AMI: 35% HF: 36% COPD: 29%

Edmonton: 1,200,000 people

AMI: 53% HF: 52% COPD: 39%

Central: 450,000 people

AMI: 39% HF: 35% COPD: 31%

Calgary: 1,400,000 people

AMI: 62% HF: 48% COPD: 36%

South: 290,000 people

AMI: 52% HF: 51% COPD: 40%

Key Messages

- The majority of patients saw a physician within a month after discharge.
- At least one-third of patients saw a physician within 7 days of discharge.
- Physician follow-up rates were higher for patients with AMI than those with HF and COPD.
- Hospitals and community characteristics had more impact on the follow up rate than patient factors.
- Follow-up visits increased when patients had a familiar community physician, especially for patients with HF or COPD.

Conclusions

- The 7-day follow-up rate was lower and showed more room for improvement.
- Improving continuity of care for patients with chronic diseases is not a simple task; however, it has value to patients and leads to better care outcomes and lower costs.
- Increasing post-discharge follow-up requires participation from patients, providers and policy-makers.
- The follow up rate might be improved through:
  - better discharge plan in small hospitals
  - better communication btw hospital and community health care providers
  - more accessibility of physician services in rural regions

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Physician Follow-Up After Hospital Discharge: Progress in Meeting Best Practices

- Find the report:

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