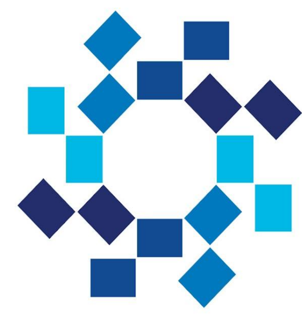


Hackensack Meridian
Hackensack University Medical Center

Increasing After Visit Summary Documentation of Post Hospital Follow-up Appointments

Inpatient Diabetes Education Team

Colette Knight MD, Diabetes Chair; Maria Soper APN BC-ADM CDCES; Sarah Duesel BSN RN CDCES; Donna Gibbons MS BSN RN CDCES; Nyasa Mitchell BSN RN CDCES; & Lucy Castelan, CMA

Hackensack Meridian Health, Hackensack University Medical Center

BACKGROUND

- The Advanced Diabetes Disease Specific Certification (DSC) promotes a culture of excellence across the organization in providing evidenced based care to patients diagnosed with diabetes. HUMC* follows ADA* Standards of Diabetes Care in the hospital, as its clinical practice guideline (CPG). Hospitalized individuals with diabetes are at two times (14-20%)[5] greater risk for readmissions than those without diabetes. Scheduling a follow-up appointment prior to discharge, increases the likelihood that they will attend a post hospital visit with a provider or endocrinologist.[4]
- Utilizing the CPG, the diabetes high risk population was defined and data collected.
- In 2021, pre-scheduling a follow-up appointment, with date and time documented on the after-visit summary (AVS) was defined as a DSC metric. Data showed that one third of HUMC high risk inpatients with diabetes, did not have a scheduled follow-up appointment noted at discharge.

Project Objective: Improve the percentage (>80%) of scheduled follow-up appointments, documented on the AVS with specific date and time, for identified high risk individuals living with diabetes (DM).

METHODS

Design:
- Multidisciplinary team approach to improve education and optimize workflow processes to increase scheduled follow-up appointments prior to discharge

Setting:
- Admitted Inpatient Adults with Diabetes at HUMC*

Measures:
- Total number of Adult "high risk" inpatients admitted with diabetes (DM); discharged home with a documented follow-up appointment indicated on the AVS*

Interventions:
- Discussed and reviewed metric data at monthly meetings; Multidisciplinary Steering, Nursing and Service Line
- Presented at Grand Rounds, Nursing Education and Care Coordination meetings
- Presented monthly to Ancillary & Nursing Orientation classes
- Discussed 1 to 1 with Case Managers; providing follow-up information, provider contact lists and support tools
- Created and distributed Diabetes Disease Specific Certification pocket cards with F/U* appointment metric

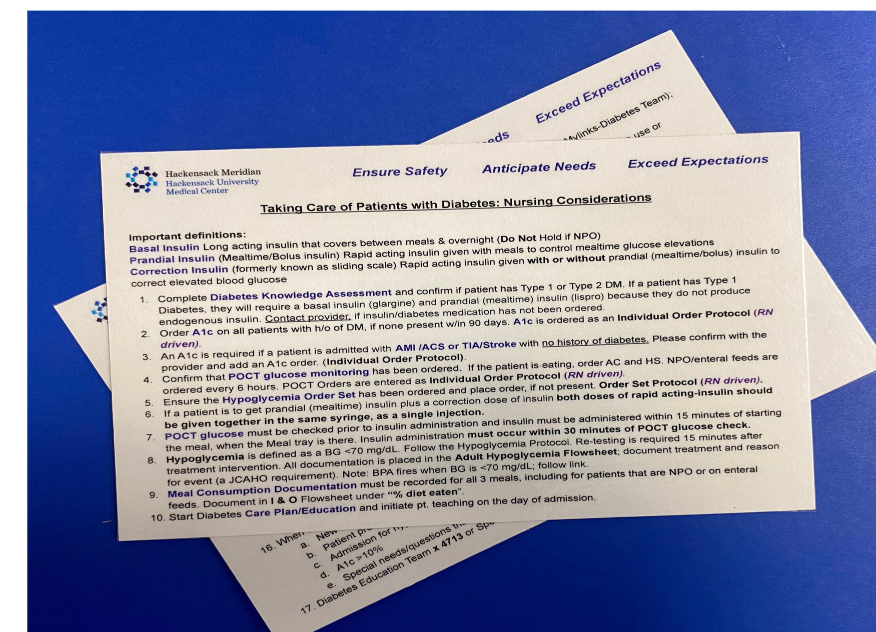
Revisions during project:
- Team created/reviewed metric data via EPIC reports
- Modified high risk group A1C; from ≥10% to ≥ 9% to capture a wider scope of "at risk" diabetes population (7/2021)
- Expanded Stakeholders to "house wide": including Attendings, Hospitalists and Residents
- Certified Medical Assistant position added to team in (8/21)
- Inclusion of Admission/Discharge Transition (ADT) Nurses (12/22)

EBP Question: For inpatient adults with diabetes (P) does scheduling a post hospital follow-up appointment via teamwork (I) increase the likelihood of discharge follow-up appointments (O) to meet Evidenced Based Practice recommendations in a high risk population (C) over an 18 month time frame? (T)

Inclusion Criteria	Exclusion Criteria
Newly diagnosed adult with diabetes	Pediatrics
A1C ≥ 9%	**A1C ≤ 8.9%**
• Diabetes ketoacidosis (DKA) admission • Hyperglycemic Hyperosmolar Syndrome (HHS) admission • Hypoglycemia admission (with history of DM)	• Scheduled VNS*,SAR* or Long term care facility • Disposition of discharge against medical advice • Deceased • Documented refusal to schedule appointment

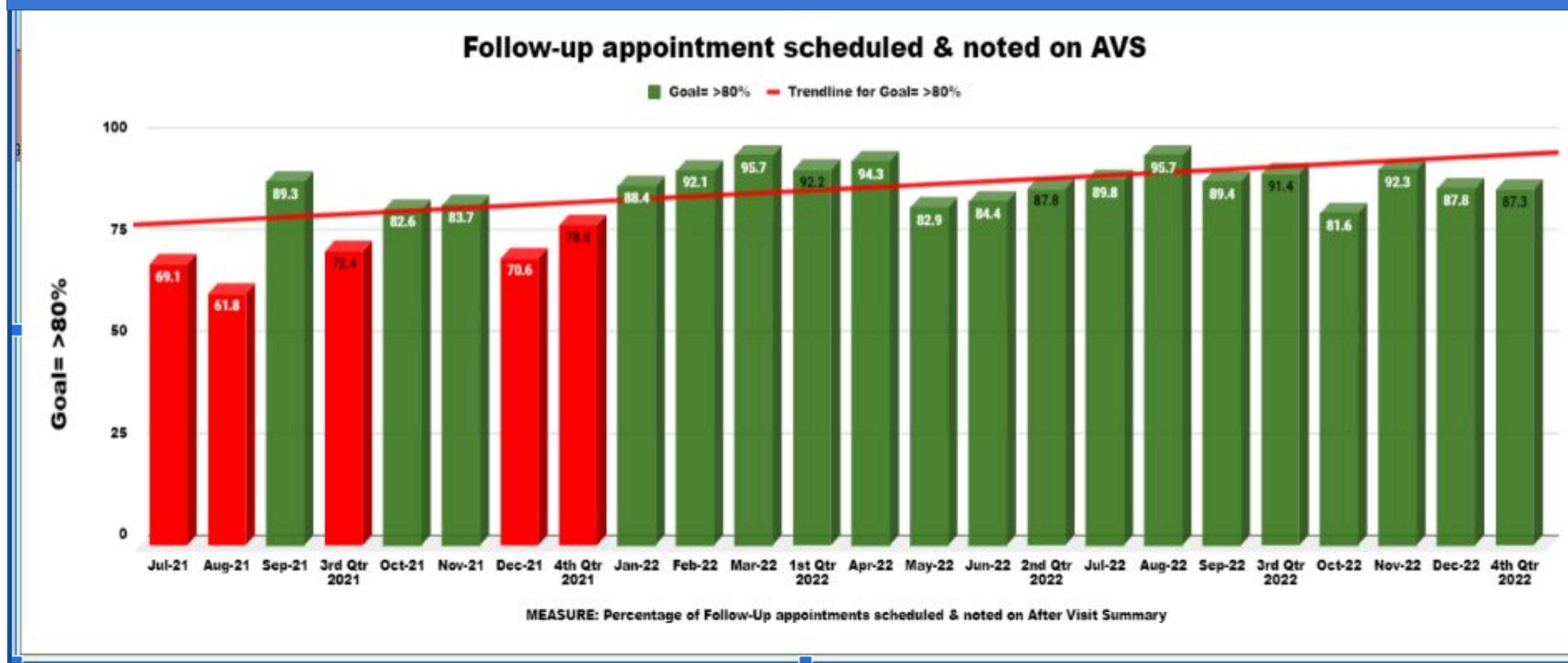
TAKING CARE OF PATIENTS WITH DIABETES: CONSIDERATIONS

STAFF SUPPORT "POCKET CARD"



13. **Collaborate with Case Manager; MD follow-up <u>is required</u> on ALL individuals with diabetes.** Document the specific date, time and place of appointment on the **AFTER VISIT SUMMARY**. The uninsured individual also requires a clinic follow-up; documented on AFTER VISIT SUMMARY with date, time and place.

RESULTS



RESULTS

Metrics	Baseline (7/2021)	Post Implementation/ outcome (12/2022)
High risk DM with a scheduled F/U* on AVS*	69.1%	87.3%

LIMITATIONS

- Case management: employee turnover (2021-22)
- Lack of identification of diabetes diagnosis indicated on History and Physical /or Diabetes Knowledge Assessment Flowsheet
- Duration of time necessary to coordinate, arrange and schedule appointments via individual and provider
- Delayed reply from various provider offices to schedule F/U appointments prior to discharge
- Inability for F/U provider to see individual within 2 to 4 weeks of hospital discharge

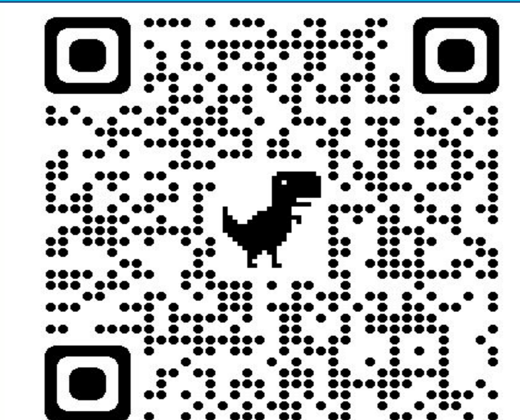
CONCLUSIONS

- Communication and patient agreement to facilitate post hospital follow-up care prior to discharge; requires availability, teamwork and collaboration.
- A multidisciplinary "team" approach makes a positive difference.
- Coordinated discharge planning, including specific notation that alerts the need for a scheduled follow-up appointment is essential.

NEXT STEPS

Develop and implement a structured discharge order set that prompts or alerts the need to schedule and document a follow-up appointment prior to discharge, in this high risk diabetes population.

REFERENCES



April 4, 2023

Abbreviations:** AVS: After Visit Summary; HUMC: Hackensack University Medical Center; ADA: American Diabetes Association; F/U: Follow-up; VNS: Visiting Nurse Service; SAR: Subacute Rehabilitation