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.
  – chronic 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

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<th>AMI</th>
<th>HF</th>
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<tr>
<td><strong>AMI</strong></td>
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<td><strong>HF</strong></td>
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<td><strong>COPD</strong></td>
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<td><strong>Index</strong></td>
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<td><strong>Hospitalizations</strong></td>
<td>8,616</td>
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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%).
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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