Patient Centered Medical Home in a Safety Net Community Health Clinic: The Transformation of Eastside Adult Clinic

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Denver Health
GIM Grand Rounds
February 7, 2012
OBJECTIVES

- Understand the components for NCQA recognition
- Define the change concepts involved in transformation to a patient centered medical home
- Learn how Eastside Adult Clinic has adopted and implemented PCMH concepts into everyday practice
Patient Centered Medical Home

- Personal Physician: continuous, comprehensive care
- Team Care: collectively takes responsibility for ongoing care
- Whole Person Orientation: takes responsibility for all patient needs by delivering or arranging care
- Coordinated Care: across all elements of the healthcare system
- Quality and Safety: continuous QI, voluntary recognition process
- Enhanced Access: via open scheduling, expanded hours, and new options for communication
- Payment: recognizes value of the PCMH, pays for coordination and electronic communication with patients, supports IT use

February 2007 ACP, AAFP, AAP, AOA joint statement
Patient Centered Medical Home

- But what is it really?
- Innovative, team-based approach to providing healthcare
- Practice team that coordinates a person’s care across episodes and specialties
- Partnership between the patient, his/her primary provider, and a health care team
- Improved healthcare access
- Improved communication and access to information
- Evidence-based processes of care
- Population-based care management
- Payment reform
Patient Centered Medical Home

- 2006 Commonwealth Fund health care survey
  - 2837 adults 18-64 years old (English or Spanish speaking)
- 4 questions asked
  - Do you have a regular source of care?
  - It is not difficult to contact the provider by telephone?
  - It is not difficult to get care or advice after hours?
  - Office visits are generally well organized and running on time?
- Medical home defined if “yes” answers to all 4 questions
- 30% reported having a medical home
- Those less likely to report having a medical home: Hispanics, uninsured, CHC patients

Patient Centered Medical Home

- Why make the transformation?
- Results from Medical Home Pilot projects have shown:
  - Better clinical quality for patients
  - Improvements in patient experience
  - Improvements in clinician/staff satisfaction
  - Opportunity for enhanced reimbursement as “medical homes”
  - Opportunity to share in savings due to reduction in ED use, hospitalizations and practice of evidence-based care
Adults with a Medical Home Are More Likely to Report Checking Their Blood Pressure Regularly and Keeping It in Control

Percent of adults 18–64 with high blood pressure

- Does not check BP
- Checks BP, not controlled
- Checks BP, controlled

Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.

Source: Commonwealth Fund 2006 Health Care Quality Survey.
Racial and Ethnic Differences in Getting Needed Medical Care Are Eliminated When Adults Have Medical Homes

Percent of adults 18–64 reporting always getting care they need when they need it

- Medical home
- Regular source of care, not a medical home
- No regular source of care/ER

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>White</th>
<th>African American</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical home</td>
<td>74</td>
<td>74</td>
<td>76</td>
<td>74</td>
</tr>
<tr>
<td>Regular source</td>
<td>38</td>
<td>53</td>
<td>52</td>
<td>50</td>
</tr>
<tr>
<td>No regular</td>
<td>52</td>
<td>44</td>
<td>31</td>
<td>34</td>
</tr>
</tbody>
</table>

Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.

Source: Commonwealth Fund 2006 Health Care Quality Survey.
Group Health Cooperative: Comparison of Clinical Quality and Staff Burnout at the Patient-Centered Medical Home Site and Comparison Clinics, 2006 to 2007

Composite Quality of Care

<table>
<thead>
<tr>
<th>Year</th>
<th>PCMH Clinics</th>
<th>Control Clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>68.1</td>
<td>63.8</td>
</tr>
<tr>
<td>2007</td>
<td>72.1</td>
<td>66.5</td>
</tr>
</tbody>
</table>

Clinician Emotional Exhaustion

<table>
<thead>
<tr>
<th>Year</th>
<th>PCMH Clinics</th>
<th>Control Clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>19.6</td>
<td>20.9</td>
</tr>
<tr>
<td>2007</td>
<td>12.7</td>
<td>21.0</td>
</tr>
</tbody>
</table>

Notes: Mean difference in composite clinical quality changes from 2006 to 2007 between clinics significant at p<0.01; difference in mean emotional exhaustion in 2007 between clinics significant at p<0.01.

National Center for Quality Assurance Physician Practice Connections-Patient Centered Medical Home

Operational approach to objectively characterize the extent to which a practice conforms to the medical home principles

3 tiers of achievement

Recognition, not accreditation

2008 standards with more of a focus on structure/EHR, less so on patient experience and outcomes (2011 standards more “patient-centered”)

Evolving product
NCQA PPC-PCMH 2008 Standards

- Access and Communication
- Patient Tracking and Registry Functions
- Care Management
- Patient Self-Management Support
- Electronic Prescribing
- Test Tracking
- Referral Tracking
- Performance Reporting and Improvement
- Advanced Electronic Communications
NCQA PPC-PCMH 2011 Standards

- **Access and Continuity**: Provide team-based care with access and advice during and after hours and patient/family information about medical home
- **Identify and Manage Patient Populations**: Acquire and use data for care of the practice’s population
- **Plan and Manage Care**: Use evidence-based guidelines for preventive, acute and chronic care management for chronic, frequent and behavior-based conditions, including medication management
- **Self-Care**: Support patient and family in self-care with information, tools and community resources
- **Track and Coordinate Care**: Track and coordinate tests, referrals and transitions of care
- **Performance Measurement and Quality Improvement**: Use performance and patient experience data for continuous quality improvement
NCQA PPC-PCMH 2011 Standards

- What is different about the PCMH 2011 standards?
  - Promotes patient-centered care
  - Emphasizes language, culturally sensitive aspects
  - Integrates behaviors affecting health, substance abuse, mental health and risk factor assessment and management
  - Integrates applicability to pediatric patients
  - Aligns with CMS Meaningful Use requirements
  - Emphasizes relationship with/expectations of subspecialists
  - Increases importance of evaluating patient experience
  - Underscores the importance of system cost-savings
  - Increases importance of using clinical performance measure results
## PPC-PCMH Content and Scoring

<table>
<thead>
<tr>
<th>Standard 1: Access and Communication</th>
<th>Pts</th>
<th>Standard 5: Electronic Prescribing</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Has written standards for patient access and patient communication**</td>
<td>4</td>
<td>A. Uses electronic system to write prescriptions</td>
<td>3</td>
</tr>
<tr>
<td>B. Uses data to show it meets its standards for patient access and communication**</td>
<td>5</td>
<td>B. Has electronic prescription writer with safety checks</td>
<td>3</td>
</tr>
<tr>
<td>Standard 2: Patient Tracking and Registry Functions</td>
<td>9</td>
<td>C. Has electronic prescription writer with cost checks</td>
<td>2</td>
</tr>
<tr>
<td>A. Uses data system for basic patient information (mostly non-clinical data)</td>
<td>2</td>
<td>Standard 6: Test Tracking</td>
<td>Pts</td>
</tr>
<tr>
<td>B. Has clinical data system with clinical data in searchable data fields</td>
<td>3</td>
<td>A. Tracks tests and identifies abnormal results systematically**</td>
<td>7</td>
</tr>
<tr>
<td>C. Uses the clinical data system</td>
<td>3</td>
<td>B. Uses electronic systems to order and retrieve tests and flag duplicate tests</td>
<td>6</td>
</tr>
<tr>
<td>D. Uses paper or electronic-based charting tools to organize clinical information**</td>
<td>6</td>
<td>Standard 7: Referral Tracking</td>
<td>PT</td>
</tr>
<tr>
<td>E. Uses data to identify important diagnoses and conditions in practice**</td>
<td>4</td>
<td>A. Tracks referrals using paper-based or electronic system**</td>
<td>4</td>
</tr>
<tr>
<td>F. Generates lists of patients and reminds patients and clinicians of services needed (population management)</td>
<td>3</td>
<td>Standard 8: Performance Reporting and Improvement</td>
<td>Pts</td>
</tr>
<tr>
<td>Standard 3: Care Management</td>
<td>21</td>
<td>A. Measures clinical and/or service performance by physician or across the practice**</td>
<td>3</td>
</tr>
<tr>
<td>A. Adopts and implements evidence-based guidelines for three conditions **</td>
<td>3</td>
<td>B. Survey of patients’ care experience</td>
<td>3</td>
</tr>
<tr>
<td>B. Generates reminders about preventive services for clinicians</td>
<td>4</td>
<td>C. Reports performance across the practice or by physician **</td>
<td>3</td>
</tr>
<tr>
<td>C. Uses non-physician staff to manage patient care</td>
<td>3</td>
<td>D. Sets goals and takes action to improve performance</td>
<td>3</td>
</tr>
<tr>
<td>D. Conducts care management, including care plans, assessing progress, addressing barriers</td>
<td>5</td>
<td>E. Produces reports using standardized measures</td>
<td>2</td>
</tr>
<tr>
<td>E. Coordinates care/follow-up for patients who receive care in inpatient and outpatient facilities</td>
<td>5</td>
<td>F. Transmits reports with standardized measures electronically to external entities</td>
<td>15</td>
</tr>
<tr>
<td>A. Assesses language preference and other communication barriers</td>
<td>2</td>
<td>A. Availability of Interactive Website</td>
<td>1</td>
</tr>
<tr>
<td>B. Actively supports patient self-management**</td>
<td>4</td>
<td>B. Electronic Patient Identification</td>
<td>1</td>
</tr>
</tbody>
</table>

**Must Pass Elements**
## PPC-PCMH Scoring

<table>
<thead>
<tr>
<th>Level of Qualifying</th>
<th>Points</th>
<th>Must Pass Elements at 50% Performance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 3</td>
<td>75 - 100</td>
<td>10 of 10</td>
</tr>
<tr>
<td>Level 2</td>
<td>50 – 74</td>
<td>10 of 10</td>
</tr>
<tr>
<td>Level 1</td>
<td>25 – 49</td>
<td>5 of 10</td>
</tr>
<tr>
<td>Not Recognized</td>
<td>0 – 24</td>
<td>&lt; 5</td>
</tr>
</tbody>
</table>

**Levels:** If there is a difference in Level achieved between the number of points and “Must Pass”, the practice will be awarded the lesser level; for example, if a practice has 65 points but passes only 7 “Must Pass” Elements, the practice will achieve at Level 1.

Practices with a numeric score of 0 to 24 points or less than 5 “Must Pass” Elements do not Qualify.
Safety Net Medical Home Initiative

- Safety Net Medical Home Initiative (SNMHI)
- Sponsored by the Commonwealth Fund
- Administered by Qualis Health and the MacColl Institute for Healthcare Innovation
- 4 year transformation project: 2009-2013
- 5 states, 65 clinics
- Colorado
  - Colorado Community Health Network
  - 13 clinics (urban and rural)
  - Denver Health: Eastside Adult, La Casa/Quigg Newton Family Practice, Westside Pediatrics
Safety Net Medical Home Initiative

- Currently under evaluation by University of Chicago
  - Do clinics become PCMHs?
  - What are the outcomes?
    - Clinical quality
    - Patient experience
    - Staff experience
    - Efficiency
  - What is associated with successful implementation?
Selected Publications from the SNMHI

  - Providers and staff in clinics with more PCMH characteristics had higher moral, but providers had less freedom from burnout
  - QI subscale on the PCMH-A correlated with higher moral, greater job satisfaction, and freedom from burnout

Eastside Family Health Center
Eastside Adult Clinic

- 2nd community health center in the US (1st west of the Mississippi)
- Patient demographics
  - Medicare: 24%
  - Medicaid: 31%
  - Uninsured: 43%
  - Commercial: 2%
- Approx. 5.5 FTE providers currently
  - Panel size ~1400 patients/FTE
- On-site lab, pharmacy, dental clinic
SNMHI PCMH Change Concepts

- Engaged Leadership
- QI Strategies
- Empanelment
- Patient-Centered Interactions
- Organized, Evidence-Based Care
- Continuous and Team-Based Healing Relationships
- Enhanced Access
- Care Coordination
Engaged Leadership

- Support PCMH activities at the clinic level
- Establish QI team that meets regularly
- Provide protected time (separate from direct patient care) to further PCMH
  - Built in time each week for PCMH activities
  - Meetings/conferences
- Build PCMH values into staff training and hiring
SNMHI PCMH Change Concepts

- Engaged Leadership
- QI Strategies
- Empanelment
- Patient-Centered Interactions
- Organized, Evidence-Based Care
- Continuous and Team-Based Healing Relationships
- Enhanced Access
- Care Coordination
QI Strategies

- Establish and monitor metrics
  - Pt-PCP continuity
  - Percent of visits at medical home
  - HTN, DM quality metrics
  - Cancer screening
  - % visits to ED/AUCC
- Patient feedback surveys
- Pull data for individual pt visits
- Utilize patient registries
  - HTN
  - DM
  - Cancer Screening
## Medical Home Continuity Metrics

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP-Pt concordance* (Pt perspective)</td>
<td>79%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>PCP-Pt concordance* (PCP perspective)</td>
<td>66%</td>
<td>89%</td>
<td>85%</td>
</tr>
<tr>
<td>Visits at the Medical Home**</td>
<td>75%</td>
<td>82%</td>
<td>90%</td>
</tr>
</tbody>
</table>

*Excludes providers that have recently left or other extended provider absence

**Percent of visits to the Medical Home out of possible medical home visits (medical home, emergency care, urgent care, other community health services)
Hypertension Clinic

- Pharmacist run clinic
- Patients are referred who are not at blood pressure goal (flagged by HCP or provider)
- Pharmacist makes medication interventions and follows up with patient until at goal
- Close communication with PCP regarding medication changes and follow-up
- November, 2011: 65% of patients with hypertension had BP <140/90
BP Trend 2008-2011

All Hypertension BP < 140/90 mm HG

Percentage

Measure Value
Trend
Target

Diabetes Care

- Focus on patients with A1c >9%
- 3 options
  - Co-located diabetes clinic (endocrinologist)
    - 1 day/month
    - Mainly referred by provider, but patients can self-refer
  - Diabetes phone management by pharmacist
    - Referred by provider
    - Warm handoff while patient in clinic
    - Insulin titration
  - Pharmacist diabetes clinic
    - Referred by provider
    - Labs checked per diabetes guidelines
DM Trend 2009-2011

Diabetes HgbA1C <= 9%

- Measure Value
- Trend
- Target

Denominator Change
QI Strategies

- Ensure that patients, families, providers, and care team members are involved in QI activities
  - **Lean events for staff**
- Utilize HIT to improve communications between patients and care teams through:
  - Online, web-based interactive support for care
  - Secure communication
  - Remote monitoring
SNMHI PCMH Change Concepts

- Engaged Leadership
- QI Strategies
- Empanelment
- Patient-Centered Interactions
- Organized, Evidence-Based Care
- Continuous and Team-Based Healing Relationships
- Enhanced Access
- Care Coordination
Empanelment

- Ensure all patients seen at clinic identify:
  - Eastside Adult as their medical home
  - PCP as their primary provider
  - Care team
- Ensure that all patients are assigned to a PCP/care team
  - Assignment is easily identifiable to anyone at Denver Health
  - Standard work followed to assign patients
  - Regular audits to ensure process is working
- Understand practice supply and demand, and balance patient load
  - Number of new visits per provider is adjusted according to total panel
- Use panel data/registries to proactively manage patients
  - Patient navigator
SNMHI PCMH Change Concepts

- Engaged Leadership
- QI Strategies
- Empanelment
- **Patient-Centered Interactions**
- Organized, Evidence-Based Care
- Continuous and Team-Based Healing Relationships
- Enhanced Access
- Care Coordination
Patient-Centered Interactions

- Respect patient and family values
- Communicate with patients in a language and at a level they understand
  - Spanish interpreter in the clinic
  - DH Spanish line
  - AT&T language line
- Encourage patients to take an active role in decision-making
  - Self-management goal setting
SNMHI PCMH Change Concepts

- Engaged Leadership
- QI Strategies
- Empanelment
- Patient-Centered Interactions
- Organized, Evidence-Based Care
- Continuous and Team-Based Healing Relationships
- Enhanced Access
- Care Coordination
Organized, Evidence-Based Care

- Planned care according to patient need
  - Up-to-date patient information available to providers/care team at the time of the visit
- Point-of-care reminders based on clinical guidelines
  - Encounter form
  - Clinical care guidelines
  - Immunization rules
**DENVER HEALTH OUTPATIENT ENCOUNTER FORM**

<table>
<thead>
<tr>
<th>Site: ENH Adult Med</th>
<th>Prim Language: ENGLISH</th>
<th>Sec Language:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: 77 Yrs</td>
<td>Temp: F 99.5, Temp C: 35.3</td>
<td>Tympanic Pulse: 68, Resp: 16</td>
</tr>
<tr>
<td>B/P: 130/87</td>
<td>Pain: No</td>
<td>Location:</td>
</tr>
<tr>
<td>WT: LB: 214, OZ: 000 KG: 97.07</td>
<td>Ht Ft: 5</td>
<td>In: 3</td>
</tr>
<tr>
<td>Meds: Yes</td>
<td>Pharmacy 1: KING SCOOPERS</td>
<td>SEC Hand Smoke: No</td>
</tr>
<tr>
<td>MCR Plan: Pharm 1</td>
<td>Pharm 2:</td>
<td>Herbs/Supplements: Yes</td>
</tr>
<tr>
<td>Latex Allergies: No</td>
<td>Med Allergies: NKDA</td>
<td>Med Allergies Verified: Yes</td>
</tr>
<tr>
<td>LMP:</td>
<td>LMP NA:</td>
<td>Family Planning:</td>
</tr>
<tr>
<td>Reason for Appt/Concerns: DM CHECK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Username: VICKI HUTZ</td>
<td>Print Time: 08:20</td>
<td></td>
</tr>
</tbody>
</table>

**Learning/Physical/Cognitive Considerations:**

- Hearing: Impaired / HOH EAR
- Vision: Impaired / GLASSES
- Speech: WNL

**Preventive Care:**

- Pap: 
- HPV: /  
- Mammo: /  
- Fobt: 07/27/10 * Not Ind 

**Comments:**

- Tetanus: 01/09  
- Rhex: 02/14/02  
- Flu: 10/19/11  
- Creat: 07/27/11 | MA: 02/08/11 | Moderately increased  
- Urine PH: 02/08/11 | 25 | Prostate CA Counseling:  
- GFR Result: > 60  
- STATINS: Yes | ACE/ARB: No | CHD Risk Score: NOT CALCULABLE DUE TO AGE  
- ASA/OHT Anticoagulation: Yes  
- Dental: 07/04/12 DEN  
- Eye: 02/15/08 | Foot: 03/10/10 | PHO: |

**Self-Management Goals:**

- PT WILL WALK FOR 1HR 3X/WEIGHT  
- 02/08/11 | Pt. Activated: Yes

**Subjective/Objective:**
SNMHI PCMH Change Concepts

- Engaged Leadership
- QI Strategies
- Empanelment
- Patient-Centered Interactions
- Organized, Evidence-Based Care
- Continuous and Team-Based Healing Relationships
- Enhanced Access
- Care Coordination
Continuous and Team-Based Healing Relationships

- Link patients to a provider and care team
- Assure that patients are able to see their provider whenever possible
  - Priority List/Sharepoint
- Distribute tasks among care teams to reflect “right person/right job”
- Cross-train care team members to maximize flexibility and ensure patients’ needs are met
Care Teams

Care Teams (6)
- Provider(s)
- HCP
- Clerk

Each RN (2) assigned to 3 care teams
Pictures of care teams at registration by each clerk
  - Improve patient recognition of their care team

Shared resources: Social Worker, Senior Plus, Behavioral Health, PharmD

All phone calls, messages, paperwork routed through and sent to appropriate member of care team
Provider can delegate work/responsibilities to appropriate member of care team (right person, right job)
Improved communication between front office and back office
Sharepoint/Priority List

- Web-based messaging system between centralized appointment center and individual clinics/care teams
- If a patient is not able to schedule an appt that meets his/her needs, he/she is placed on the sharepoint site
- Clinic RNs review multiple times/day for their care teams
- If RN unable to meet patient’s need, discussion with PCP
- Attempt to meet need through alternative contact (telephone visit, nurse visit), schedule into designated clinic use appts, or overbook appt
SNMHI PCMH Change Concepts

- Engaged Leadership
- QI Strategies
- Empanelment
- Patient-Centered Interactions
- Organized, Evidence-Based Care
- Continuous and Team-Based Healing Relationships
- Enhanced Access
- Care Coordination
Enhanced Access

- Help patients attain and understand health insurance status
  - Onsite enrollment specialists
  - Social worker/Senior plus
- Provide scheduling options
- 24/7 continuous access to care teams via phone, email, or in-person visits
  - Nurse advice line
Telephone Visits

- We are not billing for or being reimbursed for TVs
- Schedules vary per provider FTE, preference
- 3 patients scheduled into 2 patient visit slots (easy to overbook)
- Can be scheduled based off of patients from the priority list or follow-up from face-to-face visit
- To open up appointment slots on provider schedules
- Follow-up: diabetes (insulin titration), depression (med titration), chronic pain (med titration), etc...
SNMHI PCMH Change Concepts

- Engaged Leadership
- QI Strategies
- Empanelment
- Patient-Centered Interactions
- Organized, Evidence-Based Care
- Continuous and Team-Based Healing Relationships
- Enhanced Access
- Care Coordination
Care Coordination

- Link patients to community resources and respond to social services needs
- Integrate behavioral health and specialty care into care delivery (integrated, co-located, or referral services)
  - Integrated behavior health care
  - Co-located services: endocrine, anti-coagulation clinic
  - Specialty referrals
  - RN visits
- Follow-up with patients after ED visit or hospital discharge
  - Pharmacist telephone follow-up
  - Clinic use appts
Care Coordination

- Communicate test results and care plans to patients
  - No current standardized system
- Provide care management services:
  - Managed care members have access to this but not available to all patients
Integrated Behavioral Health

- Full time psychologist
- Part-time psychiatrist
  - ½ day clinic/week
  - Available at all times via email/phone
  - Patients scheduled only by provider or psychologist, no self-referral
- Integrated, not co-located, service
  - Warm handoffs at time of patient visit
  - Patients seen at time of visit
  - PCP to manage patient with support from behavioral health
- Psychologist can schedule short-term follow-up with patient (5-6 sessions) or refer to community resources
Anticoagulation Clinic

- Patients offered two options: telephone management or traditional clinic visit
- Telephone management (centralized)
  - Patients can go to any Denver Health clinic at anytime to get an INR drawn (including Saturdays)
  - Patient is contacted by phone or letter with results and dose adjustment if needed
- Face-to-face appt with point of care testing for immediate results and dose adjustment if needed
### RN Visits

- **Goal**: To provide as many services for our patients within the medical home, rather than sending them elsewhere.
- **Each RN sees patients for their care teams**
- **Foot care**
  - Toenail trimming/calluses
- **Wound care**
  - Standardized wound care assessment/flow sheet documentation
- **Diabetic teaching**
  - DM basics curriculum (education, nutrition)
  - Glucometer instruction
  - Insulin teaching
- **Other**: Weight checks, immunizations, B12 shots
Hospital Discharge Follow-Up

- Pharmacist managed telephone follow-up of all patients discharged from Denver Health within 48-96 hours of discharge
- Review of medication changes and confirmation that patients received appropriate medications
- Confirmation of scheduled follow-up appts
- Clarification of patient questions
## Hospital Discharge Follow-Up

### Data (retrospective view, not randomized):

<table>
<thead>
<tr>
<th></th>
<th>Contacted (n = 207)</th>
<th>Left Message (n=112) + Unable to Contact (n = 151)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total attendance at scheduled follow-up appointments within 30 days of discharge</strong></td>
<td>140/207 (68%)</td>
<td>120/263 (46%)</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td><strong>30-day readmission rate</strong></td>
<td>25/207 (12%)</td>
<td>53/263 (20%)</td>
<td>0.03</td>
</tr>
</tbody>
</table>

Implementation of a Pharmacist-Managed Telephonic Hospital Discharge Follow-Up Program. Anderson SL, Marrs JC, Vande Griend JP, Hanratty R.