**Appendix**

Presented below are descriptions about the approach taken for follow-up contact in the four hospitals included in the study.

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| **Hospital A: Approach for Follow-up Contact** |

**Time Period for Contact**

12 months (1/1/14 – 12/31/14)

**Design for Contact**

There were concerns among the nursing staff that follow-up contact was not reliably in place for all discharged patients. Administrative staff was chosen to make the calls because the hospital felt that they were the most familiar with telephone triage protocols. The design team included physicians, nurses, and administrative staff.

**Personnel Making the Contact**

Non-clinical, administrative hospital staff

**Mode of Contact**

Post-discharge telephone call

**Timing of Contact**

Within 72 hours

**Number of Contact Attempts**

Up to two

**Patients Contacted**

All inpatients discharged from the hospital were eligible for follow-up contact. Exceptions included patients with highly sensitive social and clinical cases, such as those who died in hospital or those with a history of abuse or neglect, guardianship issues, complex psychiatric needs, and/or hospice care.

**Contact Process**

Non-clinical staff in the hospitals’ Pediatric Call Center received daily lists of patient discharges from the hospital. Calls were made to families beginning on the day after discharge. When contact was made, the caller used a standardized script of questions and accessed the patient’s medical record to review pertinent discharge-related information. If the family could not be reached initially, an additional phone call attempt was made within the first 72 hours following discharge. Interpreters were used for non-English speaking patients and families. The call center staff triaged the calls that identified issues to a registered nurse (RN) or to an on-call provider as needed.

**Data Recording**

Call center data recording software was used to document information gathered during follow-up contact. This information was then exported to a standardized Microsoft Excel template for analysis.

**Context for Hospital Discharge Environment**

Discharge teaching was conducted mainly by a hospital nurse on the day of discharge. No process for medications filled and “in hand” prior to discharge. An in-house pharmacy was available for use. Routine telephone contact with primary care providers and scheduling follow-up appointments prior to discharge were not standards of care for all patients.

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| **Hospital B: Approach for Follow-up Contact** |

**Time Period for Contact**

25 months (9/1/13 – 9/29/15)

**Design for Contact**

Hospital administration and clinical staff recognized the need to institute a reliable way to contact families after discharge. Clinicians and administrators integrated to design the contact process.

**Personnel Making the Contact**

Non-clinical, outpatient staff

**Mode of Contact**

Post-discharge telephone call

**Timing of Contact**

Within 2 weeks

**Number of Contact Attempts**

Up to two

**Patients Contacted**

All patients discharged from medical (i.e., non-surgical) services were eligible to receive discharge phone calls. Exceptions included patients discharged from the cardiology service due to a service-specific contact protocol as well as patients who died in the hospital, who were transferred to other inpatient facilities, or who were admitted to the gastroenterology or neurology services for scheduled inpatient procedures.

**Contact Process**

Those selected for contact were called starting at 24 hours post discharge. Calls were made by the Pediatric Appointment Line Service, which is staffed by non-clinical staff who can coordinate follow up appointments and triage medical questions to the appropriate clinical staff. Calls focused on any discharge questions caregiver’s had, medication filling or access issues, and scheduling discharge follow-up appointments. Interpreters were used for non-English speaking patients.

**Data Recording**

Calls were documented in the electronic health record, which enabled data to be queried to identify post-discharge issues.

**Context for Hospital Discharge Environment**

Discharge teaching was conducted mainly by a hospital nurse on the day of discharge. No process for medications filled and “in hand” prior to discharge. An in-house pharmacy was available for use. Routine telephone contact with primary care providers and scheduling follow-up appointments prior to discharge were not standards of care for all patients.

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| **Hospital C: Approach for Follow-up Contact** |

**Time Period for Contact**

12 months (9/1/14 – 9/11/15)

**Design for Contact**

Hospital staff recognized the need to standardize follow-up contact. They were concerned about personnel and resources available to do that. Integration with health information technology specialists led to the idea of texting/emailing as a mode for making follow-up contact.

**Personnel Making the Contact**

None. A nurse practitioner (NP) contacted patients if they indicated a post-discharge issue via text/email.

**Mode of Contact**

Post-discharge text/email, followed by a triage telephone call.

**Timing of Contact**

Within 72 hours

**Number of Contact Attempts**

Up to two texts, up to two phone calls

**Patients Contacted**

General pediatric and short stay patients at an academic medical center who agreed to receive the emails/texts were contacted. Exceptions included non-English speaking patients.

**Contact Process**

A pediatric nurse practitioner (NP) on the medical team would approach families near the time of discharge and invite patients and their families to participate in text/email follow-up contact.  The NP would then complete enrollment via tablet in the patient room, during which families were asked to provide: 1) the name of the preferred primary caregiver to contact, 2) preference for either text messaging or email, and 3) caregiver’s telephone number and/or email address. An automated text message or email was then sent 24 hours after discharge with a link to an online survey, which consisted of three questions to determine post-discharge issues relating to medications, follow-up appointments, or any unanswered questions/issues. Messages were sent up to two times within 72 hours and were not sent when the NP was unavailable to triage. Caregivers who indicated a post-discharge issue on the survey were then flagged in an online dashboard that was checked twice daily by the NP, who would respond by phone as necessary (up to two phone calls).

**Data Recording**

Data for binary responses (i.e., “yes” = 1; “no” = 0) to the text/email for post-discharge issues were recorded along with the type of issue (e.g., medication).

**Context for Hospital Discharge Environment**

Discharge teaching was conducted mainly by a hospital nurse on the day of discharge. No process for medications filled and “in hand” prior to discharge. An in-house pharmacy was available for use. Routine telephone contact with primary care providers and scheduling follow-up appointments prior to discharge were not standards of care for all patients.

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| **Hospital D: Approach for Follow-up Contact** |

**Time Period for Contact**

12 months (1/1/12 – 12/31/12)

**Design for Contact**

Inpatient physicians felt the need to standardize the process for making follow-up contact. The hospitalist team converged to develop and implement the contract approach.

**Personnel Making the Contact**

Attending physicians from the hospital

**Mode of Contact**

Post-discharge telephone call

**Timing of Contact**

Within 72 hours

**Number of Contact Attempts**

Up to three

**Patients Contacted**

General pediatric and pediatric neurology patients on an attending-only hospitalist service at an academic medical center were contacted. The service had a co-management relationship with pediatric neurology, so patients with neurologic issues were a large proportion of the population.

**Contact Process**

Eligible patients discharged from the service were added to a previously created list in the electronic medical record (EMR). Attending physicians were scheduled on service in seven-day increments. Each day, the attending physician called the identified patients on the discharge list, beginning the first day after discharge. If the family was successfully reached, the physician asked a standardized set of follow-up questions and recorded the results in a standardized template in the EMR. If the family was not reached, the process was repeated daily for up to three attempts within 72 hours. If the patient was not reached at that time, a note was made on the EMR template. Interpreters were used for non-English speaking patients if the attending physician did not speak the patient’s primary language. Issues identified during the phone call were immediately addressed by the physician making the call.

**Data Recording**

A list of all discharged patients from the service was obtained by query of the hospital’s electronic data base for discharges linked to the service. Individual charts were then manually reviewed for follow-up notes, and results were recorded in a spreadsheet.

**Context for Hospital Discharge Environment**

Discharge teaching was conducted mainly by a hospital nurse on the day of discharge. No process for medications filled and “in hand” prior to discharge. An in-house pharmacy was available for use. Routine telephone contact with primary care providers and scheduling follow-up appointments prior to discharge were not standards of care for all patients.