Does the Hospital Medical Home Increase Primary Care Follow-Up among Pediatric Medical Patients?
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**BACKGROUND**
New York Methodist Hospital received funding from the New York State Department of Health to create a Hospital Medical Home (HMH) in April 2013. Goals:
1. The Hospital Medical Home sought to increase compliance with primary care hospital follow-up visits within 14 days of hospital discharge and improve medication reconciliation upon hospital discharge among Medicaid pediatric medical patients.
2. Another goal involved increasing collaboration with the inpatient and outpatient setting to identify high-risk patients who were at high risk for hospital re-admissions in order to reduce hospital re-admissions and improve patient satisfaction.

**METHODS**
A nurse practitioner/care coordinator began working with the attending physicians and resident physicians at NYMH to increase primary care follow-up among pediatric clinic patients.

- The nurse practitioner was notified of all upcoming discharges from the pediatric floor and pediatric intensive care unit and began meeting with patients and families to educate them on the importance of hospital follow-up visits.
- The NP called all pediatric & PICU discharges within 48 hours to remind them to attend a hospital follow-up visit within 14 days of discharge.
- The NP often saw these patients for their primary care follow-up visits at the pediatric outpatient clinic, especially high risk patients.

**RESULTS**
0 out of 75 pediatric patients who were admitted to the pediatric floor or pediatric intensive care unit between Jan 2012-June 2012 returned to the outpatient pediatric clinic for a primary care hospital follow-up visit within 14 days of hospital discharge. However, 45 out of 65 (69%) pediatric patients who were admitted to the pediatric floor or pediatric intensive care unit between Jan 2014-June 2014, after the implementation of the Hospital Medical Home, returned to the outpatient clinic for their primary care hospital follow-up visit within 14 days of hospital discharge.

**CONCLUSION**
The Hospital Medical Home project improved patient outcomes by increasing patient’s compliance with a primary care follow-up visit within 14 days of hospital discharge. The primary care follow-up visit sought to coordinate care between the inpatient and outpatient setting and identify patients who are at high risk for re-admission. Further research needs to be done to reduce the number of hospital re-admissions that occur among all pediatric medical patients, especially among patients with chronic conditions such as sickle cell anemia and seizure disorder.