PROJECT access NORTHWEST

HOSPITAL INPATIENT DISCHARGE PROGRAM

A Project Access Northwest Primary Link program

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Fact Sheet

WHAT is the Primary Link Hospital Inpatient Discharge Program?

Project Access Northwest has developed a new **Hospital Inpatient Discharge Program**. In this program, Primary Link Coordinators work with hospitals to help coordinate appropriate follow-up care for low-income uninsured and Medicaid patients prior to their inpatient hospital discharge. Coordinators contact the patients directly and schedule follow-up appointments with primary care providers. The goal is to have an appointment within 14 days of discharge.

Providence Regional Medical Center Everett was the first to partner with Project Access Northwest in 2016 to implement this program throughout its in-patient hospital system.

WHO does this program serve?

The program is designed to help hospital systems better serve their most vulnerable patients and reduce costs associated both with inappropriate use of the emergency department and with high readmission rates. **The program model can be adapted to meet the varied needs of hospital systems and community safety net clinics.**

HOW does the Hospital Inpatient Discharge Program work?

At **Providence Regional Medical Center Everett,** Project Access Northwest logs into the hospital database to monitor a discharge report throughout the day. When a patient is placed on the discharge list, the Primary Link Coordinator initiates contact with the Health Unit Coordinator and then connects directly with the patient to arrange convenient follow-up care. The Primary Link Coordinator schedules the appointment directly with the appropriate community health center or primary care provider and reports back to the patient. The patient also receives reminder calls from the primary care provider. The appointment information is included in the discharge information a patient receives.

WHY is the Hospital Inpatient Discharge Program important?

When a patient is discharged from the hospital, having follow-up care with a primary provider within 14 days **greatly improves recovery** and long-term health outcomes and also **reduces patient readmission rates and emergency department utilization** for the same condition. Having a primary care home also **helps a patient address ongoing health issues while avoiding the costs to both the patient and hospitals of unnecessary or inappropriate tertiary care.**

Follow-up care with a primary provider greatly improves recovery and long-term health outcomes.

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