

Evaluation of a Post-Discharge Follow-Up Process on Patient Care in the Primary Care Clinic: A  
Pilot Study

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## Background

Hospitalizations constitute one of the most expensive sources of medical expenditures in the U.S. health care system while modern rates of preventable hospitalizations due to chronic illness are increasing. Close to 20% of Medicare beneficiaries are being re-admitted to hospitals within 30 days of discharge due in part to expedited discharges and inadequate or no transition of care between the discharge physician and patient's primary care provider (Orszag & Emanuel 2010). Orszag and his colleagues note: "More than half of these readmitted patients have not seen their physician between discharge and readmission, and a recent study suggests that better coordination of care can reduce readmission rates for major chronic illness." Consequently, potentially preventable hospitalizations such as these debilitate the nation's health care system with excessive costs and drain resources that could be more effectively used in various other facets of the system.

Moreover, while hospital staffing resources are increasingly stretched to accommodate growing inpatient volume, primary care providers, responsible for coordinating their patients' medical care, are commonly not notified at the time that patients are admitted to or discharged from the hospital, identifying a startling communication gap in the system that promotes insufficient follow-up care after discharge (Kripalani, LeFever, Phillips, Williams, Basaviah & Baker 2007). Kripalani notes that, "delayed communication or inaccuracies in information transfer among health care professionals, particularly during the early post-discharge period, may have substantial implications for continuity of care, patient safety, patient and clinician satisfaction, and resource use." Improving the way that inpatient and outpatient health care providers communicate is imperative for improving the quality of patient care.

In FY 2013, in accordance with the Patient Protection and Affordable Care Act (PPACA) of 2010, the Medicare program will begin to target hospitals that have high hospital re-admission rates for medical problems that were not resolved during the first hospital course (Stone & Hoffman 2010). As a result of this stipulation, Medicare will reduce its payment to hospitals with readmission rates in the top 25 percent. Knowing that insufficient discharge planning and care coordination following the patient's hospital stay can lead to undesirable health outcomes such as the development of new or worsening conditions, preventable hospital readmissions, medical or medication errors and additional adverse events, Holland and Hemann (2011) studied the influence of a standardized discharge planning process on patient outcomes at the Mayo Clinic. After streamlining the discharge planning process and redefining the role of Discharge Planning Nurse Specialist, the results of their study found a "clinically meaningful decrease in length of [hospital] stay for a group of older patients at greater risk for complex discharge plans."

Though hospitals are primarily responsible for ensuring the health and safety of their patients at discharge, resource-constrained hospitals struggle to provide patients with the comprehensive discharge planning needed to assure a safe and prepared transition home. In the exploration of a solution to combat this lack of resources, Dudas, Bookwalter, Kerr and Pantilat (2001) investigated the effectiveness of pharmacists making follow-up calls to patients two days after their hospital discharge as an extension of the hospital's discharge planning procedure. Pharmacists called patients to gauge their understanding of the medication orders provided at discharge and to clarify any problems or questions that patients had with their medications. Dudas' study concluded that pharmacists were effective in avoiding additional ER visits from patients and increased patient satisfaction in their role as extended discharge planners.

Last but not least, pivotal research by Misky, Wald & Coleman (2010) explored the effects of receiving timely post-discharge follow-up care from a primary care provider on hospital readmission rates, without affecting the method of follow-up care provided. Compounding the inherent challenges in ensuring effective hospital communication, the authors noted that, "in patients who do have a PCP, post-hospitalization follow-up is frequently impacted by a variety of factors, including co-payment requirements, transportation issues, lack of health insurance, as well as scheduling a follow-up appointment while in the hospital." In addition, uninsured patients are more vulnerable to gaps and failures in the system, experiencing poorer health outcomes and being three times more likely to visit an ER following discharge compared to insured patients. In Misky et al's study, "timely" follow-up was that which occurred within 4 weeks of the patient's hospital discharge. Their research concluded that patients who did not receive timely outpatient follow-up after discharge experienced higher rates of readmission, displayed a non-significant trend of longer hospital stays and may have benefited from timely primary care provider follow up.

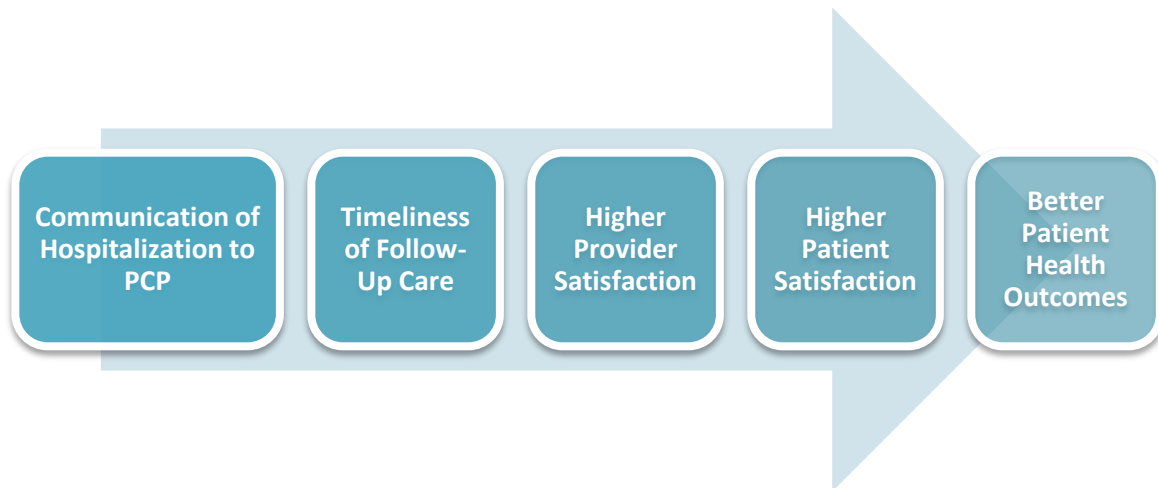
Employing more comprehensive discharge planning for patients at the hospital and utilizing pharmacists to perform follow-up calls to check medication adherence and understanding after patients return home have both been shown to be effective in the transition of post-discharge medical care. Yet effectiveness studies, measured by follow-up time and preventable admissions, of standardized post-discharge telephone follow-up protocols between primary care providers and patients have yet to appear in the published scientific literature. The literature provides evidence that follow-up telephone calls from pharmacists to patients can be effective in supporting patient transitions between hospital providers and primary care providers. Standardized post-discharge telephone messaging protocols for

notifying primary care providers who are already familiar with their patients and responsible for coordinating their care might present a feasible solution to a complicated problem.

### Research Questions

1. Will a post-discharge telephone follow-up protocol initiated by the primary care provider's office reduce the average number of days between a patient's discharge from the hospital and first office or telephone follow-up evaluation?
2. Did patient satisfaction with the follow-up care they received increase after the implementation of a post-discharge telephone follow-up protocol in these primary care clinics?
3. Did clinician satisfaction increase?
4. Was the follow-up protocol implemented as intended?
5. Could this protocol be generalized to other settings and present a viable solution for reducing the number of potentially preventable hospital re-admissions related to chronic illnesses?

### Study Design: Conceptual Model



**Figure 1.** Conceptualization of hospital follow-up process in primary care

The conceptual model for this study stems from the tenets of quality improvement. Based on a review of the literature, follow-up calls to patients after hospital discharge are not a novel concept, but initiating these calls at the primary care office adds innovation to the conventional definition of hospital discharge coordination. This conceptual model begins when a patient is hospitalized. This hospital event would first be communicated by the hospitalist and medical records forwarded to the primary

care provider for review. Upon the patient's discharge from the hospital, the primary care team would contact the patient within 3 days of discharge (or other as determined by the hospitalist and primary care team) to perform follow-up. This follow-up call provides an opportunity for the primary care team to check in with the patient and fully act as the patient's care coordinator throughout the health care system. Timely follow-up care would also boost provider satisfaction, increase patient satisfaction and lead to better health outcomes for the patient.

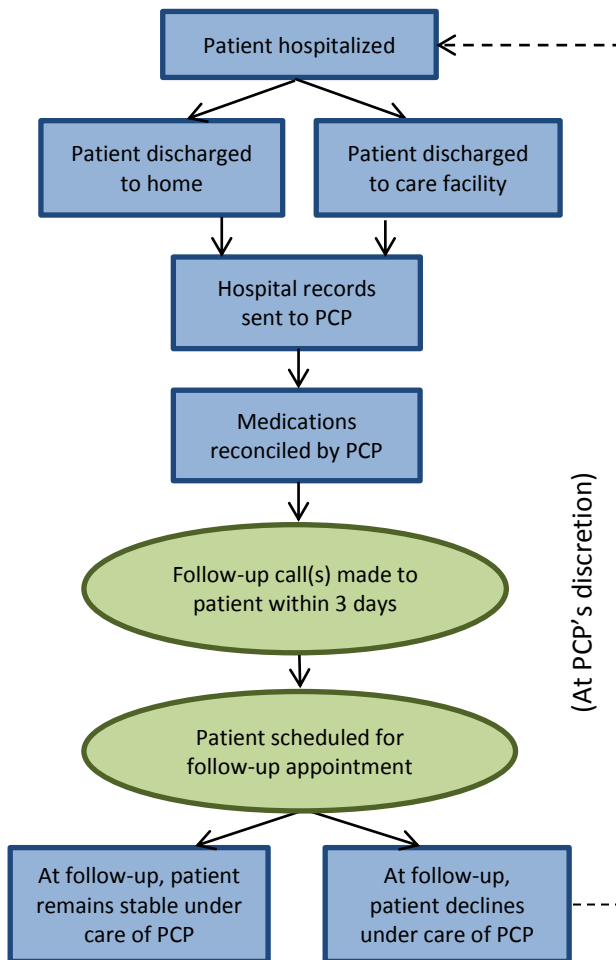
## **Methods**

### **Study Setting and Participants**

The setting for this quality improvement study is a network of urban primary care direct practice clinics located around the Puget Sound, specifically in Seattle, Mercer Island, Kent and Tacoma. The targeted population includes a convenience sample of all patients within this primary care network who had recently visited an emergency room for care or been hospitalized. The majority of patients meeting this description were older adults and Medicare beneficiaries with a mean age of 57 years and median age of 60 years. The study design is an impact evaluation of a post-discharge telephone follow-up protocol initiated by the primary care team to coordinate the transfer of care between the hospital and clinic.

No additional staffing resources were required and the primary care clinics that received this intervention were direct practices comprised of patients who pay a monthly fee direct to the provider and consider it their medical home. As such, insurance coverage, or lack of it, cannot be a barrier to accessing follow-up care in this study.

## Description of Protocol



**Figure 2.** Flow diagram of a successful post-discharge follow-up process

The ideal post-discharge protocol would begin when a patient hospitalization or ER evaluation occurred. The primary care team would receive notification of the hospital encounter via receipt of medical records or receipt of a call from the patient or hospital. Upon receipt of hospital records, the on-staff pharmacy technician would be notified and would electronically reconcile medications from the hospital encounter. This pharmacy technician was responsible for alerting the primary care provider to any inconsistencies between medication lists. After the patient returned home following discharge from the hospital, the clinician's assistant or triage nurse would make a phone call to the patient to check general recovery status, if the patient had questions about his/her discharge instructions or medications, or if the patient had experienced any side effects or adverse events after leaving the hospital. The patient would then be scheduled for an office visit with the primary care provider in the clinic if follow-up was advised at the time of discharge. To aid in this protocol's success, clinicians were

encouraged to provide suggestions for improvement of the follow-up process, and objectives for quicker record retrieval from the hospital to the primary care provider were developed and implemented.

### **Data Collection**

The first research question in this study investigates whether the length of follow-up time (in days) between a patient's hospital discharge and first contact by the primary care provider would be reduced as a result of a standardized post-discharge process in the clinic. To measure this, data were abstracted from medical records to calculate the total number of hospitalizations, the mean and median number of elapsed days between the patient's discharge and follow-up from the primary care team, the overall percentage of patients who received either telephone or in-office follow-up, total numbers of repeat ER visits for unresolved problems and total numbers of hospital readmissions for unresolved problems between the pre- and post-test periods.

The second research question asks whether changes in patient satisfaction between the pre-test and post-test periods could be identified. To measure changes in patient satisfaction, post-discharge satisfaction surveys were sent to patients to capture their level of satisfaction with the follow-up care they received by their primary care provider. These surveys were distributed continuously for several months, chronicling 3 months prior to the implementation of the process and then 3 months following the implementation of the process. Patients were mailed a survey within 3-4 weeks after their ER visit or hospital discharge date, told that their anonymous answers will be used to improve the quality of post-discharge services and remained unaware of the study intervention. Because patient perception of follow-up care is a time-sensitive concern, only one survey was sent to patients following their discharge from the hospital during each testing period. If a patient was re-admitted or if a patient did not return a survey, no second survey was sent out of respect for the patient's health concerns. The survey questions posed to patients are included in the appendix to this report.

The third research question queries whether changes in clinician satisfaction between the pre-test and post-test periods could be detected. To measure changes in clinician satisfaction, cross-sectional surveys were distributed before the standardized protocol was implemented to ascertain the clinicians' process for following up with patients following an ER or hospital discharge. Survey questions included: what worked well about their process, what worked least well, and what they would like to see in a standard process for all clinics. After all data had been collected, results were presented to the clinicians and semi-structured feedback was solicited regarding the differences they had experienced in workflow

since implementation of the standard process, which (if any) of their needs had been met, which needs remained unmet and whether they felt that the clinic had achieved any improvement from the pre-protocol stage.

The fourth research question investigated whether the standardized post-discharge protocol was implemented in the clinic as intended. To answer this, the primary care providers and support staff in the clinic were asked independently about the progress, strengths and weaknesses of the protocol. Semi-structured feedback about the protocol was collected from these two groups. Medical record data concerning the number of completed follow-ups to patients after discharge (used to answer question one above) were also utilized to determine how consistently the post-discharge protocol was fulfilled by clinical staff.

The fifth and final research question concerning the viability that this protocol can scale to a more generalized setting was answered based on the culmination and success of data collected for questions one through four.

## **Data Analysis**

To answer our first research question, data were primarily collected from medical records of patients either hospitalized or seen in an emergency room between the pre- and post-protocol implementation periods. Total numbers of hospitalizations and ER visits were accumulated while total instances of completed follow-up after discharge and average follow-up time (in days) per provider were tracked. After abstracting follow-up time (in days) from every hospitalization available in medical records during the testing periods, the distribution of these follow-up data was graphically displayed in a boxplot (Figure 2 below). An independent t-test was then conducted to test for significance in the length of follow-up time by the primary care provider that had elapsed between the pre- and post-test periods. This t-test was conducted using a 95% confidence level and the null hypothesis was that no change in follow-up time would be detected between the pre- and post-implementation periods.

For the second and third research questions respectively, data depicting differences in clinician experience and differences in patient satisfaction between the pre- and post-test periods were collected via surveys of patients and interviews with providers. Semi-structured feedback from the providers was coded based on the prominence of the themes expressed. Patient survey responses examining the patient's perception of the follow-up care they received and their overall satisfaction with this care were totaled and coded numerically. The difference in mean survey responses between the pre- and post-

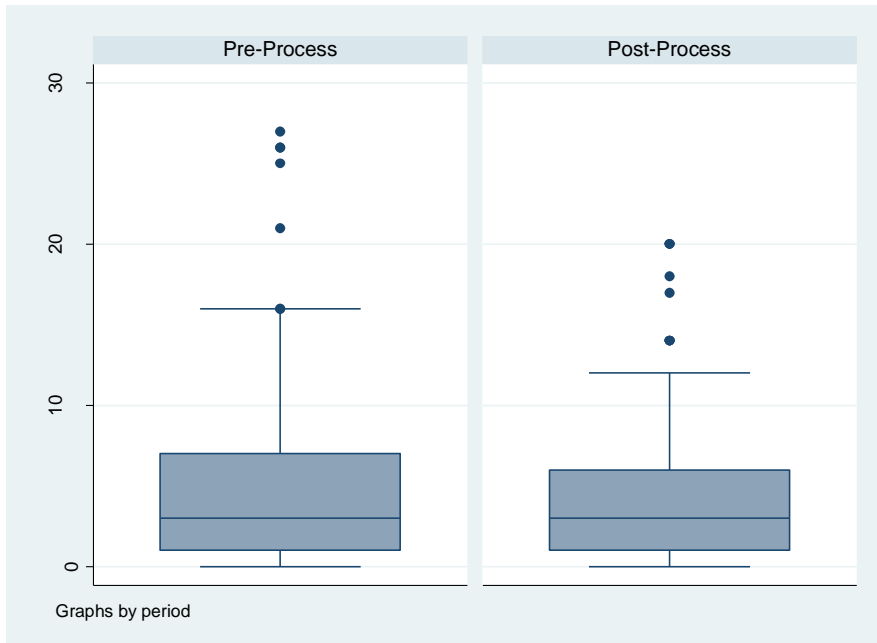
test periods would be tested for significance using an independent t-test with a confidence level of 95% and the null hypothesis was that no change in patient satisfaction would be detected between the pre- and post-implementation periods.

For our fourth research question, feedback from the clinic staff was analyzed qualitatively and coded into primary themes based on relevance to the question of interest. For the fifth research question, the answers to the four previous research questions were independently and dependently analyzed to produce a viability estimate for the generalized outlook of the post-discharge protocol.

## **Findings**

To answer our first research question, medical records maintained during the pre-process period from August 1 and October 31, 2011 logged a total of 109 qualifying hospital events across all clinics. The mean age of patients included in this sample was 58 years and the median age was 61 years. Hospital events did not qualify for follow-up analysis if the patient passed away during the hospital admission or if the patient had not yet established with a primary care provider at one of the clinics. Of these 109 events, 63 were visits to the ER only and 46 resulted in hospital admissions. During this period of time, 9 repeat ER visits and 4 hospital readmissions for unresolved problems were recorded.

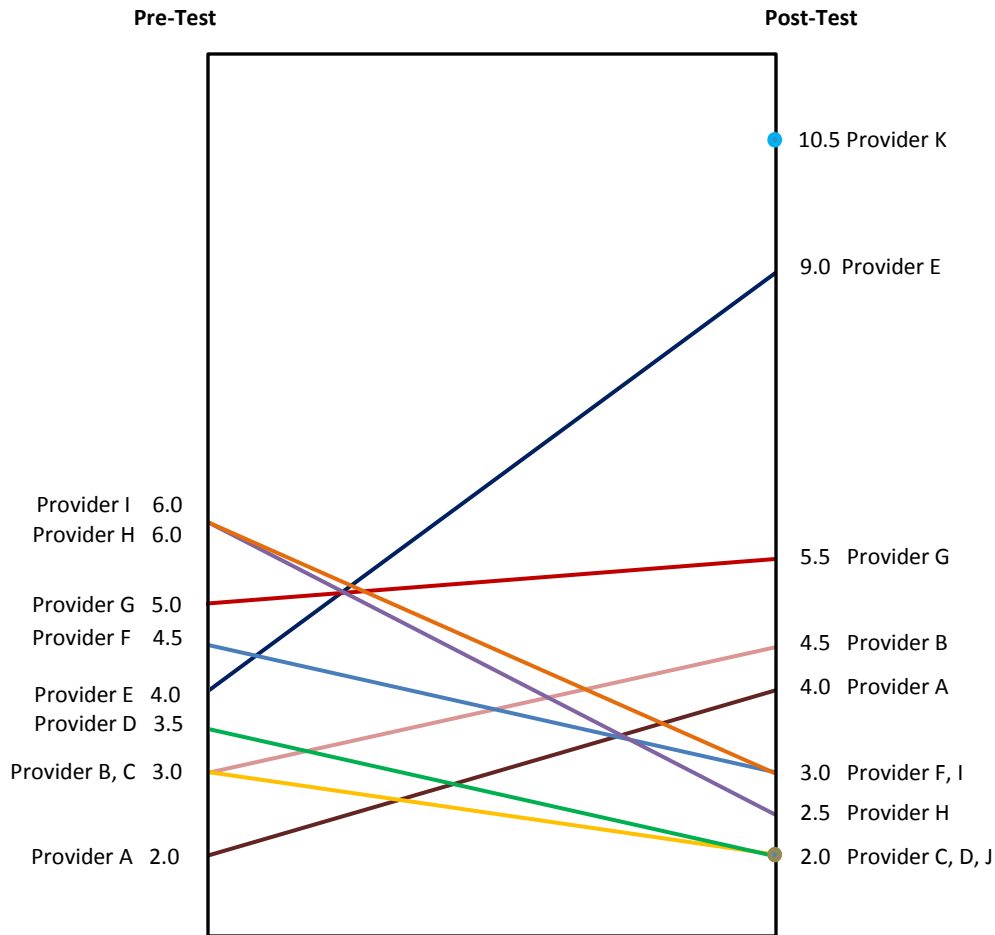
During the post-process period from November 15, 2011 and February 15, 2012, a total of 110 hospital events were logged across all clinics. The mean and median age of patients included in this sample was 56 years. Of these events, 57 were visits to the ER only and 53 resulted in hospital admissions. During this same period of time, 5 repeat ER visits and 8 hospital readmissions for unresolved problems were recorded. These readmission data, however, are limited by the short test periods and small sample sizes and are also slightly confounded by a subset of severely sick patients for whom PCP follow-up would likely not have prevented a repeat ER visit or hospitalization.



**Figure 3.** Variation in follow-up time between testing periods

Between the pre- and post-process periods, results of the independent t-test showed no significant change between overall mean and median follow-up time across all clinics. During the pre-test period, the mean time to follow-up with patients after discharge from the ER or hospital was 5.41 days and post-test showed a slight decrease to 4.76 days. Median follow-up time remained steady at 3 days between both testing periods. However, the post-test period did show that the variation in follow-up time (in days) decreased as seen in Figure 3 above. Follow-up data stratified by provider, seen in Figure 4 below, show that changes in follow-up time continued to vary by provider style. It should be noted that Providers J and K joined the practice during the post-test period, and no pre-test data are available as a result. On secondary analysis of the data, this time excluding Provider J (with the highest outlying data point), the mean time to follow-up with patients after discharge drops from 4.76 days to 4.65 days. This result does not provide a significant finding but does show that excluding the single largest outlier from the data successfully decreases the variance in provider follow-up time by 0.11 days.

Interestingly, the percentage of follow-up care provided to patients based on total hospital events increased from 87.2% during the pre-process period to 92.7% during the post-process period, resulting in a 5.5% increase in follow-up care provided to patients in conjunction with the implementation of the process. These data may also be found in Table 1 located in the appendix of this report.



**Figure 4.** Median time to follow-up with patient after ER/hospital discharge (in days)

With regard to the second research question, too few patient surveys were returned to meet the required sample size for the independent t-test for significance. Further research needs to be conducted in this area to determine whether the changes seen in patient perception of follow-up care are substantial. The response rate for patient surveys was 26% in the pre-process period and 28% in the post-process period. Of those surveys received, patients reported a 36% increase in satisfaction with the time taken by the primary care team to follow-up, a 31% increase in patients reporting confidence in their primary care provider's understanding of their current state of health, a 25% increase in satisfaction with the primary care provider's ability to clarify the patient's questions or concerns and a 25% increase in overall satisfaction with the follow-up care received between the pre- and post-test periods. Again, due to the low response rate, these data should be viewed strictly as preliminary and not representative of the population at large.

Lastly, with regard to the third research question, clinician satisfaction did not change significantly between the pre- and post-protocol periods, based on the semi-structured feedback provided by the

providers. Reasons for this response included unclear communication of follow-up responsibility between the providers and their support staff, confusion resulting from centralized medication reconciliation, and the low visibility of the post-discharge protocol by the providers. Results of the fourth and fifth research questions are discussed below.

**Table 1.** Deconstruction of research questions posed within this study

Research Question	Findings	Data Source and Method of Data Analysis
1. Will a post-discharge telephone follow-up protocol initiated by the primary care provider's office reduce the average number of days between a patient's discharge from the hospital and first office or telephone follow-up evaluation?	Possibly. Pre-protocol data exhibited quick follow-up time (in days) overall, limiting the extent to which post-protocol data could create an improvement.	Medical records; independent t-test for significance
2. Did patient satisfaction with the follow-up care they received increase after the implementation of a post-discharge telephone follow-up protocol?	Possibly. Prelim data show that patient satisfaction appeared to increase between the pre-protocol and post-protocol periods. Further research needs to be conducted to ensure reliability.	Patient surveys collected during the pre- and post-protocol periods; independent t-test for significance
3. Did clinician satisfaction increase?	No. Overall, satisfaction did not increase between the pre-protocol and post-protocol periods but provider support for the process was strong.	Semi-structured feedback from medical providers; coding of qualitative data
4. Was the follow-up protocol implemented as intended?	No, due to staff confusion of resulting from poor communication from the primary care provider and little detail about the patient's hospital encounter.	Semi-structured feedback from medical providers and support staff; coding of qualitative data
5. Could this protocol be generalized to other settings and present a viable solution for reducing the number of potentially preventable hospital re-admissions related to chronic illnesses?	Possibly, for patients with a dedicated primary care provider. A larger-scale study evaluating the effect of timely primary care follow-up on hospital outcomes needs to be conducted to ensure reliability and validity of these data.	Results of questions 1 – 4

## Discussion

The first research question posed by this study was whether a post-discharge telephone follow-up process initiated by the primary care provider's team would reduce the average number of days between a patient's discharge from the hospital and first office or telephone follow-up evaluation. Pre-protocol data presented stronger than expected results, which made post-protocol change more difficult to achieve. As such, there was no significant change between pre-protocol and post-protocol mean and median numbers of days between hospital discharge and follow-up by the primary care provider's team. Further, this study was not able to account for follow-up calls not documented in the electronic medical record, so estimates of follow-up time could be conservative. Also, based on surveys received, some patients exhibited confusion concerning the role of their primary care provider in hospital coordination. These patients sometimes neglected to inform their primary care providers about their hospital encounter and were sometimes difficult for providers to reach for follow-up.

The second research question queried whether patients' satisfaction with the follow-up care they received increased after implementation of the post-discharge follow-up protocol. During the post-protocol period, patient satisfaction did increase from the previous period, but further research should be conducted to ensure reliability of this phenomenon. The third research question posited whether clinician satisfaction increased after implementation of the protocol. Clinician satisfaction did not change between the pre- and post-protocol periods. By the end of the study, clinicians were unsure whether a centralized medication reconciliation process was the most accurate way to reconcile patient medications based on information provided in the hospital discharge summary. Clinicians also exhibited a willingness to take a more active role in delegating and managing follow-up tasks to their assistants.

The fourth research question explored whether the follow-up process was implemented as intended. This process likely experienced implementation challenges due to underutilization of follow-up forms by clinical staff and technical impediments. For instance, the current electronic medical record system employed by these clinics provides no good way for multiple users to track follow-up data. As such, a full electronic form was difficult to implement but a paper form also became an inconvenient mode for tracking real-time patient data. During a post-protocol team meeting, support staff exhibited confusion with their responsibility in the follow-up process as a result of poor communication from the patient's primary care provider and having too little information regarding the patient's hospital encounter.

Finally, the fifth research question explored whether generalizing this process to other settings could present a viable solution for reducing the number of potentially preventable hospital re-admissions related to chronic illnesses. In this study, the small sample size and short time frame produced very few hospital re-admissions, resulting in data that were not generalizable. However, because this network of clinics exhibited such a high rate of follow-up during the pre-process stage, other clinics with a weaker hospitalization follow-up process could improve their care by instituting a similar protocol. Further research should be done with a larger sample size and longer time frame to depict the representative impact of a post-discharge follow-up process initiated by primary care providers on hospital re-admissions.

### **Study Limitations**

One of the main limitations in this study is the lack of interoffice communication between the hospital and primary care provider. Inadequate communication between medical providers is one of the most challenging obstacles within the health care system and this study does not attempt to address that. The goal of this study was to initiate a standardized post-discharge follow-up protocol when hospital events were communicated effectively. Designing an intervention to improve communication between all medical providers is the next step in improving hospital care coordination and quality.

Other limitations of this study reflect inherent limitations of survey methods. Patients asked to remember a past event may suffer from recall bias in which their estimates of the events that took place may be exaggerated or muted depending on their recollection. Mailed surveys also suffer from nonresponse or selection bias in which those who do respond often have outspoken opinions concerning the follow-up care they received. One final limitation is that a successful post-discharge follow-up protocol at the clinic level requires dedicated support from the medical director and the entire clinical staff. Trusting clinical teams to follow through with the design of this or a similar program is imperative for realizing its goals.

### **Conclusion**

Communication of patient hospitalizations between hospitals, primary care provider and patients remains one of the most pressing issues in streamlining health care delivery, while costs from excessive hospitalizations continue to strain health care spending in the U.S. (Kripalani, LeFever, Phillips, Williams, Basaviah & Baker 2007; Misky, Wald & Coleman 2010). The impetus for this study was to investigate how effectively a standard post-discharge follow-up protocol implemented by a primary care clinic can

avoid potentially preventable hospital re-admissions for chronic illness. Results from this post-discharge follow-up intervention and previous research studies suggest that making follow-up calls to patients may lead to improved communication between health care providers and patients that prevents further hospitalizations. Additional research is warranted to examine how similar follow-up processes can affect patient health outcomes and monetary spending.

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## Appendix A

**Table 2.** Comparative findings from testing periods.

	<b>Pre-Process</b>	<b>Post-Process</b>	<b>Change</b>
<b>Total hospital events</b>	<b>109</b>	<b>110</b>	<b>+1</b>
- <b>Total ER-only visits</b>	<b>63</b>	<b>57</b>	<b>-6</b>
- <b>Total hospitalizations</b>	<b>46</b>	<b>53</b>	<b>+7</b>
<b>No. of repeat ER visits within 30 days</b>	<b>8</b>	<b>4</b>	<b>-4</b>
<b>No. of hospital readmissions within 30 days</b>	<b>3</b>	<b>7</b>	<b>+4</b>
<b>Median # of follow-up days (clinic-wide)</b>	<b>3</b>	<b>3</b>	<b>0</b>
<b>Mean # of follow-up days (clinic-wide)</b>	<b>5.41</b>	<b>4.76</b>	<b>-0.65</b>
<b>Follow-up %</b>	<b>87.2%</b>	<b>92.7%</b>	<b>+5.5%</b>

## Appendix B

**Table 3.** Mailed survey questions to patients.

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1	Did your primary care provider visit you while you were in the hospital?
2	How well did you understand the discharge instructions given to you when you left the hospital?
3	How well did you understand the role of your primary care provider in your follow-up care?
4	Where did you go upon discharge (your own home, someone else's home, a transitional care facility)?
5a	How long did it take for your primary care provider to contact you regarding your ER or hospital experience after you returned home?
5b	How satisfied are you with this follow up time?
6	How confident are you in your primary care provider's understanding of your current health status?
6	How well did your primary care provider answer any questions or concerns that you had after your hospital experience?
7	Overall, how satisfied were you with the follow-up care you received by your primary care provider?

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