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Bridging the Continuum of Care Using Post Discharge Calls

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Overview

Supporting and partnering with patients across the continuum of care is an essential element of patient centered excellence, and delivering quality outcomes for our patients. Now, more than ever before, this partnership matters, as much for the care experience as for driving financial performance for our organizations. A critical component and best practice in the caregiver-patient partnership is how we manage the transition from hospital to home. We have all heard the adage: discharge planning begins at admission. Clearly, much emphasis and work has been placed making sure we meet the clinical demands for each patient while also anticipating discharge planning requirements.

Despite these efforts, many patients experience anxiety, uncertainty about their readiness to care for themselves, and confusion about medications following hospitalization, to name a few. These factors, plus many others, can contribute to avoidable re-admissions and missed opportunities to give our patients proper clinical intervention when post-discharge problems arise.

Recognizing Our Glaring Gaps

The Discharge Instructions Dimension is the highest scoring dimension on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. According to Hospital Compare (2013), 84 percent of the time patients report "Yes," that they were given information about what to do during their recovery at home. So, from strictly a Survey standpoint, it appears we have the discharge process under control. Yet we know that patients actually do receive "discharge instructions" 100% of the time! This contradiction becomes a very real quality and cost concern based on estimates that Medicare is spending an approximately $17 billion dollars on unplanned hospitalizations (1).

Given health care reform agendas, addressing unplanned and inappropriate hospitalizations is (for lack of a better term) "low hanging fruit". Beginning October 1, 2012, all Medicare patients who are discharged and subsequently readmitted within 30 days with Acute Myocardial Infarction, (AMI) Heart Failure and Pneumonia will be subject to reduced payments.

Given these glaring gaps, we need to hold up the mirror and recognize Discharge Planning is a hospital-centered, one directional process (from us to the patient/family). *Were patients given written discharge instructions? Did they get the opportunity to ask questions?* Yet, it is not until the patient gets home that we providers have the opportunity to complete the Discharge as a Patient Centered Process. It is not until the patient gets home that they begin to execute the "self-care" plan and run into real-life questions that a Discharge Checklist may or not address. Even when we perform discharge phone calls, many times the questions being asked by patients during the calls are very different than the issues addressed during the official hospital discharge process (6). Even more startling is that patients are not able to

actively perform the self-care tasks described and assigned to them during discharge process (6).

Closing the Gap to Assure Patient Centered Excellence Upon Returning Home

Clearly a disconnect exists when capable clinicians and support teams are working behind the scenes, and with patients and families, to assure the best clinical quality and appropriate length of stay, yet re-admissions are among the top priorities for Centers for Medicare and Medicaid Services (CMS). Our work at Baptist Leadership Group has identified a critical lever to ensure we extend the continuum of care outside of the walls of our hospitals and emergency rooms by creating an unparalleled partnership with patients and their loved ones: Post Discharge Calls.

We can adjust our potential blindspots by paying attention to several tools and resources to create patient centered excellence in extending our hospital walls to the home environment.

Know your key measurements
Re-admission Risk: What patients are most vulnerable for re-admissions for your inpatient and emergency populations? Do you have appropriate or inappropriate readmissions for patients with AMI, Heart Failure and Pneumonia diagnoses?

HCAHPS: Three of the 10 HCAHPS dimensions have a direct impact on helping us identify opportunities to support patients and their loved ones prepare for discharge:

- Information to Care for Self at Home (aka Discharge Instructions),
- Care Transitions (the newly added HCAHPS dimension) and
- Medication Communication

These dimensions provide us with an indication of performance (the percent of times our patients say we prepared them to go home, communicated purpose and potential side effects of medications, and helped them understand the purpose and importance of their medications and home care needs) and national ranking (how well we do on those items relative to all other hospitals).

These measurements, if broken down by unit will help leaders identify ways to integrate outcomes, as well as the voice of the patient, into patient experience and education improvements.

Ensure Consistent Patient Centered Communication- Every Patient Every Time
Adopting a patient centered communication model ensures that we are engaging patients and their loved ones in the discharge preparation process. Without two-way communication and validation of understanding and skill transfer, we are vulnerable to unnecessary readmission,

patient anxiety and dissatisfaction upon returning home, and failure to empower patients and their loved ones to "speak up" when problems arise.

BLG's **RELATE** model for patient centered communication provides staff and physicians with a tool for educating patients and their loved ones to

- Help them prepare for discharge
- Understand the purpose and importance of post discharge care plans and medications
- Anticipate needs they may have upon returning home
- Identify potentially dangerous medication effects or clinical problems that require medical intervention

Step 1: Reassure
Reduce anxiety and concern by sharing your qualifications and experience; manage up the facility and the medical team as well; give patients and their loved ones confidence in their ability to follow home care routine and medication schedule

Step 2: Explain
Describe in clear, concise language what the patient can expect to experience. Use readily understandable terms. Use teaching aids whenever possible to support understanding of home care instructions, activity limitations and medication prescriptions

Step 3: Listen
Focus attention actively on the patient and their family and encourage them to ask questions. Look for both verbal and non-verbal cues that indicate a patient has a concern, anxiety or lacks understanding. Ask open-ended questions like "what concerns do you have?".

Step 4: Answer
Respond appropriately to patients' questions or concerns by summarizing what patient said and then answering. Confirm their understanding.

Step 5: Take Action
Perform the task or procedure at hand for the patient, narrating your care or process as you go. Let the patient know what is happening each step of the way. It is important to narrate your care as you begin the task or procedure, and throughout. Ask patients and their loved ones to teach back the instructions or care practices to you to validate their understanding and skill

Step 6: Express Appreciation
Thank the patient and their loved ones for allowing you to care for them, and for selecting your healthcare organization. Gratitude reinforces that the medical team is honored to care for their loved one and creates loyal patients.

Adopt Post Discharge Phone Calls

Nearly every organization we encounter has a process (or multiple processes) for discharge phone calls. Much organizational time and energy goes into these phone calls to patients; however, they rarely produce world-class clinical and experience outcomes. Our assessment of organizational discharge call processes typically reveals gaps in effectiveness, focused inquiry, follow up, reward and recognition, accountability for improvement and trending to understand patterns.

In order for Discharge Phone Calls to achieve the best patient care results, it must be a systematic and disciplined. Ideally, the calls are driven by clinicians. Solely calling patients post discharge to improve public relations or improve satisfaction will not elicit necessary feedback to evaluate if a patient has experienced a complication and/or requires post visit support. Instead, providers should proactively address post visit follow-up as a critical extension of acute and emergency care services.

Based on our depth and breadth of experience at Baptist Health Care and with our partners across the country, we recommend organizations use the following identified best practices for discharge phone calls.

1. Establish a Standard Process:

- Identify target populations of patients. For instance,
  - Emergency Department high risk groups
  - Inpatient high risk groups (AMI, HF, Pneumonia) and solid and high performing units with good outcomes and deployment of Rounding and Patient Centered Communication
- Call patients within 48 hours of discharge and speak directly with the patient whenever possible
- Set expectation with patient at the time of discharge that a call will be made within 48 hours post discharge to evaluate how well they have adjusted to their care at home or post discharge. Validate correct phone contact information.
- Follow a consistent communication protocol for all patients. BLG has developed a Discharge Call Implementation Planner and coaching process to reduce variation and ensure optimal outcomes of discharge calls. We also have Eclipse Post Discharge Call Solution, our web-based technology tool that streamlines and standardizes discharge calls.
- Communication protocol should include precise questions directed at determining the patient's progress and/or assess potential red flags in the patient's condition
- Staff executing discharge phone calls should call from an undisturbed location
- Staff should reassure and encourage patients to speak open and honestly about their recovery progress and challenges they are experiencing
- Build the opportunity for patients to ask questions into your call protocol; prepare to focus your inquiry in the event that patients have no questions as continued dialogue may trigger or remind patients of questions or concerns that they have

2. Capture Feedback Systematically:

- Capture all patient feedback data in a discharge phone call database (Eclipse Discharge Phone Call Solution); make certain key fields are either "pre-populated" or entered for all patients such as medical record number, discharge identifier, diagnosis and other necessary care and care team information
- Focus your inquiry and be prepared to probe for any challenges they are facing with the following:
    - Availability of getting the prescriptions filled
    - Understanding their medications and the side effects related difficulties
    - Care environment feedback
    - Nursing care feedback
    - Questions or concerns for their care team
    - Staff to recognize or complement

3. Take Action and Follow Up:

- Provide patients with clarifying information based on their concerns
- Intervene to correct problems with the patient's condition and refer patients to appropriate caregivers (e.g., physician, Social Worker, Emergency Care, Nurse, pharmacist, emergency department) when necessary.
- Reward and recognize staff and physicians based on patient feedback
- Implement service recovery best practices if failures occurred in the patient experience
- Create systems of accountability when complaints occur or the patient shares feedback of missed expectations; coach staff and physicians for improvement

4. Evaluate:

- Analyze Discharge Phone Call data to look for trends in complications, questions and feedback as a means to proactively address post discharge care
- Link to actual outcomes to ensure Discharge Phone calls reduce readmissions

Creating Positive Outcomes

Our experience with creating a patient centered discharge process will create significant gains for your organization.

People

Improved employee morale results due to perceived benefits of the discharge phone call service and positive feedback received (7).

Service
Patients receiving discharge phone calls are statistically significantly more satisfied with medication instructions (2).

Quality
- Statistically significant differences in ED visits within 30 days of discharge (10% call vs. 24% no call) (2).
- Fewer patients are readmitted within 30 days of discharge (15% call vs. 25% no call) (2).
- Pharmacists identified and resolved medication-related problems for 19% of one study group (2).
- Patients who do not receive discharge phone calls are at an increased risk of not detecting and/or proactively addressing adverse events after discharge. In one study, 11% of patients had a preventable adverse event (6%) or an adverse event that could have been ameliorated (5%) (10).
- Improved smoking cessation rates among patient's treated for an acute myocardial infarction (2)

Finance
In an intervention group of 110 patients, The University of California saved $11,910 in averted Emergency Department visits based on discharge follow up calls vs. the control group. This type of savings could potentially add nearly $375,000 to UMMC's bottom line in terms of unnecessary Emergency Department visits (2).

Growth
Discharge Calls enable an organization to appropriately route patients to receive any required care. In instances where patients require medical attention, they are encouraged to seek care from a physician and/or the emergency department (2, 6,7).

Citations

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