A Positive Discharge "Touch": Implementation of a Centralized Nurse-Led Hospital Discharge Telephone Call Program

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Background

Why Phone Calls?

- Hospital discharge is a significant transition for patients and caregivers as they assume management of complex treatment plans in the home environment.
- Telephone follow-up is a best practice to support patients during this transition period to clarify discharge instructions, review medications, evaluate symptoms, and facilitate outpatient handoffs.
- As part of California's "Bridge to Reform" CMS program, UCSFMC re-engineered and expanded the follow-up phone call program for inpatients, the ED, and peri-op services.
- This call program uses an automated interactive phone call paired with a centralized pool of specially trained RNs who assist patients and families with transitional care needs.

Literature Review

- Nearly 20% of Medicare patients are readmitted within 30 days, costing $17.4 billion in 2004. Only 50% of these readmitted patients had seen their PCP prior to readmission (Jencks et al., 2009).
- Post-discharge phone calls are recommended as part of comprehensive programs to improve care transitions, because they can improve clinical outcomes, reduce patient anxiety, and provide an opportunity for rapid service recovery (Shupe, 2014).
- With decreasing reimbursements and penalties for readmissions and low satisfaction scores, healthcare systems worry that they will have to absorb unsustainable costs (Hansen, Young, Hinami, Leung, & Williams, 2011).

Original Program

- Manual calls by unit RNs working a few hours/week calling their patient populations only (5 services only)
- Clinical call only (no satisfaction question)
- Unable to meet the 48-72 hour target for transition call
- Hand-off difficult as RNs did not work centrally

Program

Implementation Goals

- Attain and sustain a reach rate of at least 75%
- Understand patient needs in the acute transition period
- Capture timely clinical and satisfaction data & feed back to providers

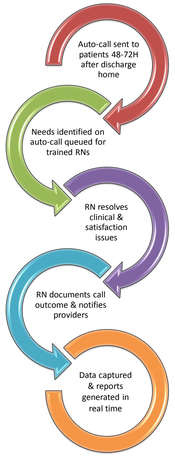
Implementation Process

- CipherHealth® VOICE pilot September-December 2013; program purchased January 2014
- Established interdisciplinary implementation workgroup to vet the call scripts and pilot workflows
- Established protocols for triaging to providers
- Educated staff nurses, coordinated with Patient Care Managers
- Weekly reports provided by CipherHealth® facilitated changes to the script, workflows, and escalation/triage protocols early on
- Established formal relationships with pharmacy and Patient Relations Department to access the call data and interact with patients directly for medication and satisfaction issues
- As of 12/31/2014, implemented the discharge calls to 60% of adult and pediatric services
- Designed & implemented multi-call programs (up to 5 calls in 30 days) for Medicare populations of Heart Failure and Total Hip and Knee replacement

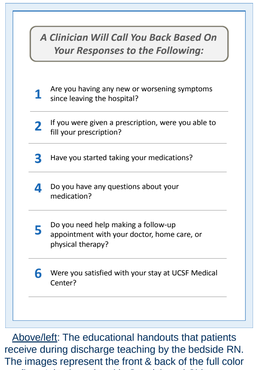
Program Components

- Revised data capture for clinical and satisfaction issues
- Discharging RN & patient education at time of discharge
- RN caller education, standard workflow development, and competency maintenance
- RN caller issue resolution with patients/families
  - Collaboration with Pharmacy, Patient Relations Department, inpatient & outpatient providers (attendings, residents, and NP/PAs), case management & social work, home care agencies
  - Standard workflow to communicate with providers with the EHR
- Report creation and generation
  - Retreat with interdisciplinary representation for input
  - Disseminate to services at staff/practice meetings

Outcomes



Right: Executive Summary Report for 9/1/13-6/30/14. A patient is considered "reached" when he answers the automated call and responds to at least the first clinical question. Follow-up time is the total time needed to resolve all patient issues, once identified by the automated call; this number includes Sunday automated calls that cannot be addressed until the call center is open on Monday.

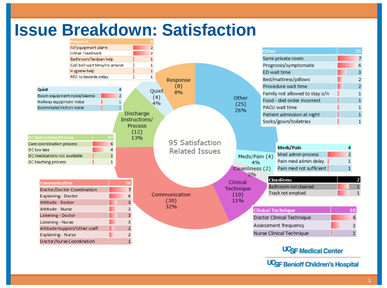


Above/left: The educational handouts that patients receive during discharge teaching by the bedside RN. The images represent the front & back of the full color flyer. It is also printed in Spanish and Chinese.

Hospital Service (Go-Live Date)	Patients Attempted	Patients Reached	Reach Rate (Opening Question)	Patients Requiring Callback (#)	Patients Requiring Callback (%)	Average Follow-up Time (Hrs)
Hospital Medicine (9/23)	3453	2450	71%	1043	43%	9
Neurology (11/4)	258	178	69%	79	44%	7
Neurosurgery (11/4)	1323	1015	84%	494	45%	10
Neurovascular (11/4)	95	70	74%	35	50%	12
Orthopedics (10/14)	864	717	83%	383	53%	9
Plastic Surgery (10/14)	163	141	87%	62	44%	9
Cardiology (1/13)	750	570	76%	222	39%	9
CHF (1/13)	91	75	82%	22	29%	3
Electrophysiology (1/13)	99	79	80%	38	48%	9
Gyn Onc (6/22)	18	17	94%	11	65%	5
Vascular Surgery (3/26)	141	124	88%	55	44%	6
Total/Average	**7255**	**5436**	**75%**	**2444**	**45%**	**8**

Nurse Caller Actions	Number of Actions (801 patients)
Helped Obtain Prescriptions	59
Helped Coordinate Home care/OP Services	60
Helped Schedule Appointment	98
Notified Specialist	192
Notified Inpatient Provider	201
Notified PCP	232
Notified Mid-level Provider	393
Total	1235

Above: Interventions required by the RN callers on the callbacks for 3/10/14-1/1/15. The clinical documentation platform was improved after our February 2014 retreat (at which input was gathered from multidisciplinary workgroups).



Right: An example of a quarterly report. This data represents the satisfaction issues that the RN callers identified for the Pediatric Hospital Medicine service 8/1/14-11/30/14, and was presented to the service leaders in addition to the breakdown of clinical issues.

Conclusions

Challenges

- Initial scepticism about patient acceptance of automated phone call
- Understanding the acute transition needs of diverse & complex patient populations
- Provider and staff communication/escalation preferences not consistent, difficult to standardize

Evaluation

- Creating a centralized program, leveraging technology and dedicated nursing expertise, has resulted in operational efficiencies
  - Improved reach rates and time to resolution of patient issues
- Data can be reviewed weekly allowing for immediate changes to call scripting and workflow
- Keys to success of the program include the staffing model, with specific training and competencies, communication procedures, and service-specific escalation protocols
- Formal collaborations with pharmacy and patient relations staff have been established with early, positive response
- Data and patient feedback are being used to improve the discharge and transitions processes
- Once implemented hospital-wide, the program will improve the quality of patient transition, enhance the patient experience, and assure that the final discharge "touch" is positive

Next Steps

- FY 2015 Work Plan: complete program implementation
- Formal partnership with Population Health Department to better manage complex patients
- Add LACE (risk for readmission) score to RNs dashboard and create workflows for moderate and high risk patients

References & Acknowledgement

- References available on request

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