MAXIMIZING DISCHARGE PHONE CALLS

High Impact Practices and Processes to Realize Results

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 on 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. These factors, in addition to others, can contribute to avoidable re-admissions and missed opportunities to give our patients proper clinical intervention when post-discharge problems arise.

RECOGNIZING THE 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 (2019), 87 percent of the time patients report, "Yes," that they were given information about what to do during their recovery at home. From a CAPHS 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 has become clearer with the introduction of the Care Transitions Dimension on HCAHPS. Care Transitions offers a deeper glimpse into our opportunities to improve as only 53% of patients report "Top Box" for feeling prepared to leave the hospital. Additionally, given health care pay for performance incentives and goals to reduce healthcare expenditures, addressing unplanned and inappropriate hospitalizations has become an obvious aspect of providing safe quality care.

Given these glaring gaps, we need to hold up the mirror and recognize that Discharge Planning is all too often 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? Even with this, it is not until the patient arrives at home that we providers have the opportunity to complete discharge as a patient-centered process, and it is not until the patient arrives at 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. Even more startling is that patients are not able to actively perform the self-care tasks described, agreed-upon, and assigned to them during discharge process.

CLOSING THE GAP TO ASSURE CARE EXCELLENCE UPON RETURNING HOME

Clearly a disconnect exists when capable clinicians and support teams are working behind the scenes 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 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 through Discharge Phone Calls.

We can minimize our potential blind spots by paying attention to the discharge call resources to create patient-centered excellence and extending our hospital walls to the home environment

KNOW YOUR KEY MEASUREMENTS

Re-admission Risk: Which 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 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
- 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 WITH DISCHARGE INSTRUCTIONS AND DISCHARGE CALLS

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.

PRC Excellent Accelerator's CARES macro-competency for highly reliable patient experiences, 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

C is for Confidence

Instilling patients' confidence in us means that they believe you understand and can speak to their needs. We must also encourage their confidence in speaking up and asking all the questions they may have. This requires our openness, ability to listen for what is not said as well as what is said, and a willingness to take charge of the conversation and help our patients through it successfully. We also instill confidence through our non-verbal behaviors—our smile and encouraging tone of voice.

A is for Anticipating Needs

We have a prime opportunity with discharge teaching and discharge calls to anticipate our patients' needs. When providing discharge teaching, provide written materials as resources and refer to these during teaching. We understand their most frequently asked questions and concerns and can prepare these responses ahead of time so that we make sure to address all aspects of the issues.

R is for Respectful Communication

Describe in clear, concise language what patients can expect to experience and what next steps they can expect. Use readily understandable terms without jargon. Refer to previously given or online resources whenever possible to support understanding of home care instructions, activity limitations, and medication instructions.

E is for Engage in Care and Process

During discharge teaching, focus actively on patients and their families and encourage questions. Look for verbal and non-verbal indications of understanding, concern, anxiety, or lack of understanding. Ask open-ended questions such as, "What concerns do you have?" and invite dialogue. Actively listen to ensure understanding of your patients' questions.

S is for Say Thank You or Safe Transition

Never overlook the opportunity to say thank you and to make a safe transition—in this case, to home. Be sure to tell your patients when they should make contact for medical help (and what is "normal") and how they can easily do so. Gratitude reinforces that the medical team is honored to care for their loved one and creates loyal patients.

BEST PRACTICES FOR DISCHARGE PHONE CALLS

1. Establish a Standard Process:

- Identify target populations of patients. For instance,

    - Emergency Department's high-risk groups.
    - Inpatient high-risk groups (AMI, HF, Pneumonia) and solid and high performing units with good outcomes.
- Deploy Rounding and CARES processes.
- 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. PRC Excellence Accelerator works with clients to develop Discharge Call Planners and coaching processes to reduce variation and ensure optimal outcomes of discharge calls. Additionally, we can work with any outsourced firm or technology application to maximize the impact of the calls and subsequent performance improvement.
- Communication protocol should include precise questions directed at determining the patient's progress and/or assessing 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 if 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; 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.
- If discharge phone calls are captured via an application or IVR tool, establish standing reports to evaluate trends and address immediate patient care needs or comments.
- Focus your inquiry and be prepared to probe for any challenges they are facing with the following:
    - Ease of getting prescriptions filled.
    - Understanding their medications and the side effects and any related difficulties.
    - Care environment feedback.
    - Nursing care feedback.
    - Questions or concerns for their care team.
    - Staff to recognize or compliment.

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 to proactively address post discharge care.
- Link to actual outcomes to ensure Discharge Phone calls reduce readmissions.

For more information on how PRC Excellence Accelerator can support your Discharge Phone Calls or improvement efforts, contact Barry Fleming at BFleming@prccustomresearch.com.