



POST-DISCHARGE CALL PROGRAMS

IMPROVING SATISFACTION AND SAFETY

BY MARK WILLIARD

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For patients coming home from the hospital after surgery, an emergency department (ED) visit or any other inpatient stay, the change in location has both positive and negative possibilities. On one hand, because the patient is returning to familiar surroundings and routines, recovery may be easier. On the other hand, it may be harder.

In a home environment, discharged patients can be lulled into a false sense of security and resume normal activities, causing them to neglect their discharge instructions. For older patients, especially patients taking multiple medications, the discharge instructions can be particularly difficult to recall. Still other patients may not have a support network to help them comply with discharge instructions.

For all of these patients, the prospect of post-discharge complications, such as an infection, or a medication error, is likely. In fact, a study funded by the Agency for Healthcare Research and Quality (AHRQ) and published in the *Annals of Internal Medicine* found that one in five patients has a complication or adverse event after being discharged from the hospital (Forster, et al., 2005).

Hospitals have developed several strategies to solve this problem, ranging from discharge planning programs to partnering with nonacute providers in a patient's transition from the hospital. But no single strategy completely solves the problem. Discharge planning programs require resource-intensive efforts, and non-acute care provider solutions rely on resources that may or may not be under the hospital's control and may be too complex to implement or maintain.

A third option that has emerged is establishing proactive post-discharge calling programs, staffed by trained healthcare professionals. Most of these post-discharge call programs focus on surgical, cardiac, and ED patients, the patients most at risk for post-discharge complications. Research shows that patients who receive detailed after-hospital care instructions are 30% less likely to be readmitted to the hospital or to visit the emergency department than uninformed patients who've recently been discharged (Jack et al., 2009).

Recent studies have reported that approximately 12% of patients develop new or worsening symptoms within a few days post-discharge (Kripalani, et al., 2008), and adverse drug events can occur in between 23% and 49% of people during this transition period (Forster, et al., 2005).

One emergency department study evaluated patients older than 75 and found a nurse liaison could effectively assess the complexity of a patient's questions and appropriately advise them over the phone or triage them to the correct provider for further care (Poncica, et al., 2000).

In a study evaluating resource use in heart-failure patients, researchers found that follow-up calls significantly decreased the call group's average number of hospital days over 6 months and readmission rate at 6 months, as well as increased patient satisfaction (Riegel, et al., 2002).

CREATING A CALL PROGRAM

BENEFITS OF CREATING IN-HOUSE CALL PROGRAMS

- Ready access to patient records.
- Brand reinforcement.
- Ability to involve actual members of the patient's care team.
- Opportunity to identify or prevent adverse events before they escalate.
- Possible increase of patient satisfaction scores and likelihood of referrals.

SHORTCOMINGS OF HOSPITAL-BASED CALL PROGRAMS

- Most reach only a fraction of discharged patients because other work gets in the way.
- Some hospitals cannot staff the call center at night, when discharged patients are most reachable.
- Inability to consistently staff with trained callers.
- Increases staff workload.
- Decreases staff's availability to attend to inpatients, which may negatively effect satisfaction scores and the likelihood of referrals.

BENEFITS OF OUTSOURCING POST-DISCHARGE CALL PROGRAMS

- Outreach program can be run day or night to ensure patients are contacted.
- Reduces burden on hospital staff.
- Costs are minimal compared to using hospital staff.
- Employs trained callers, possibly with clinical experience.
- Opportunity to identify or prevent adverse events before they escalate.
- May increase patient satisfaction scores and likelihood of referrals.
- Results immediately compiled in a central location in an electronic format.

SHORTCOMINGS OF OUTSOURCING POST-DISCHARGE CALL PROGRAMS

- Initial unfamiliarity with hospital branding messages.
- Lack of linkage with patient scheduling system, unless call center handles this duty.
- Calls may or may not be handled by personnel with sufficient medical knowledge.
- Requires additional administration, reporting key data in patient records.

The goals for post-discharge call programs vary, but most focus on:

- Ensuring that patients comprehend their discharge instructions and medication regimen.
- Capturing information about new symptoms that may indicate a problem with recovery.
- Decreasing readmissions.

The benefits are wide ranging, from reduced workloads for hospital staffs, to reduced readmissions and post-discharge errors, to improved patient satisfaction scores.

Managing Patient Safety: Avoiding Post-Discharge Medication Errors

A recognized value of post-discharge call programs is the opportunity to resolve a common, avoidable complication: medication errors. Medication errors or medication emergencies after discharge can occur for a variety of reasons, such as the patient not understanding the right dosage or inappropriately taking the hospital prescribed medications with over-the-counter medications or other prescriptions that were not reviewed and approved through the hospital's medication reconciliation initiative. Health statistics show that there are more than 700,000 ED visits each year for adverse drug events, with nearly 120,000 of these episodes resulting in hospitalization.

The likelihood of an adverse drug event increases significantly in patients using more than five medications and when there is a lack of understanding of how and why they are taking certain medications. A review of the top reasons for medication errors bears this out (Table 1).

Post-discharge calls present a way to ensure discharged patients aren't added to these ranks. Hospitals that are making use of aggressive post-discharge calling have signaled that at least 6 out of 10 of these medication error opportunities could be addressed through the calls. The challenge for many hospitals is dedicating resources to maintain a consistent outreach program.

Managing Quality: Preventing Infections Over the Phone

Almost any person is susceptible to developing an infection soon after being discharged from the hospital. Among the discharged population, surgical patients, patients with weakened immune systems, and patients who were in the hospital because of an infection are top candidates for post-discharge infections. Epidemiologists also warn of increased prevalence of methicillin-resistant *Staphylococcus aureus* bacteria in hospitals and the community at large.

A primary challenge discharged patients face is that they may not notice new symptoms immediately, especially if the new symptoms are masked by medications, patients are alone, or if patients are distracted by other ailments or pain. Distinguishing infections from normal aches and pains associated with recovery can be difficult for another reason. Most patients have the mindset they are "better" when they leave the hospital, and don't typically suspect that they could get worse, so they often don't realize when new symptoms appear.

Post-discharge calls present an opportunity to uncover adverse events before they escalate. This is also why well-executed, post-discharge call programs include standardized scripts matched by good listening and

interview skills to identify initial signs of medical complications in time to initiate early intervention.

The ability of this type of program to impact the quality of care is demonstrated by the experience at IPC, The Hospitalist Company, based in North Hollywood, Calif. IPC initiates calls to patients within 48 hours of discharge through a national call center that is staffed by patient representatives and nurses. They report that they are able to resolve 90% of identified clinical issues through the post-discharge calls.

Managing Patient Satisfaction: Improving Perceptions

The AHRQ study states that not understanding discharge instructions is one of the top eight "dissatisfiers" to patients (Forster et al., 2005). In contrast, a Press Ganey study cited in the Studer Group's Hardwire Results found that patients who received post-discharge calls that helped them understand their care regimen were more likely to recommend the calling hospital and to say they were satisfied with their nursing care (Setia & Román, 2008).

Hackensack University Medical Center (HUMC), a 781-bed teaching and research hospital affiliated with The University of Medicine and Dentistry of New Jersey–New Jersey Medical School, began calling patients after discharge in both the acute care setting and the ED in 2006 (Setia & Román, 2008). An evaluation of this program demonstrates that it successfully builds patient satisfaction and loyalty.

Perhaps adding to satisfaction levels is that post-discharge calls can have benefits for inpatients. Britt Berrett, president and chief executive officer of Medical City Hospital in Dallas, recognized this benefit when he opted to outsource Medical City's triage calls. Medical City wanted to allow nurses more time to attend to inpatients. By outsourcing triage calls, Berrett found he was able to reduce the nursing staff's responsibilities, freeing them to care for patients with less distraction.

Managing Payers and Reporting with Post-Discharge Call Documentation

Most of the hospitals that have implemented post-discharge call programs utilize nurses, nurse practitioners, or pharmacists to conduct calls, or rely on firms that employ healthcare professionals and/or trained medical counselors. The calls usually occur within 2 or 3 days of discharge and help fill in the information void that is created when the patient leaves the direct care environment.

While ensuring patient safety is the primary reason for the call, it also enables a hospital to document the patients who are intentionally non-compliant with discharge

Patient and system-associated factors in descending order of frequency:

1. Non-intentional non-adherence.
2. Discharge instructions were incomplete, inaccurate or illegible.
3. Conflicting information from different informational sources.
4. Duplication of medications.
5. Money/financial barriers.
6. Intentional non-adherence.
7. Did not fill prescription.
8. Incorrect label on prescription bottles.
9. Medications prescribed with known allergies/intolerances.
10. Patient confusion between brand and generic names.

Table 1. Top 10 Reasons for Medication Errors Post Discharge

Source: Adapted from E. A. Coleman, J. D. Smith, D. Raha, & M. S-J, Min. (2005). Posthospital medication discrepancies: Prevalence and contributing factors. *Archives of Internal Medicine*, 165, 1842-1847.



Mark Williard is senior vice president of Beryl, a healthcare exclusive call center, where he oversees product management to support more than 450 hospitals, health systems, and private practices' call center programs. Williard may be contacted at mark.williard@beryl.net.

instructions. As hospitals are fast approaching an era when they will be penalized by Medicare and other payers for readmissions, proving that a patient contributed to the need for readmission will help hospitals avoid the reimbursement penalties. In these instances, MedPAC has stated that the patient's readmission won't be counted against the hospital's readmission rate.

Because public reporting of quality scores, including readmission rates, is a consistent theme in every future vision of healthcare, protecting your organizations quality scores by documenting patient behavior following discharge is a key step in protecting an organization's reputation.

Looking Ahead: Turning the Telephone into a CMS Tool

Post-discharge calls may ultimately prove to be a defense against a major challenge for The Centers for Medicare & Medicaid Services: readmissions. According to a Commonwealth Fund-supported study in

the New England Journal of Medicine, one out of five Medicare beneficiaries discharged from the hospital is readmitted within 30 days, and half of non-surgical patients are readmitted to the hospital without seeing an outpatient doctor in follow-up (Jencks, et al., 2009). CMS has declared that many of these rehospitalizations are preventable and estimates that they cost the government nearly \$17 billion annually.

In April 2009, CMS announced the Care Transitions Project, a program in 14 communities aimed at eliminating these "unnecessary" readmissions by creating more seamless transitions from hospital to home. As CMS tests plausible solutions and hospitals inside and outside of the pilot vet their options, implementing an aggressive, consistent post-discharge call program may emerge as one of the most efficient. Every healthcare provider knows that caring for patients doesn't stop when they are discharged, and with the right call program, patients will see that too.

SCRIPTING THE POST-DISCHARGE CALL

The typical script being used by hospitals that are committed to post-discharge calling consists of these common questions:

- Have you experienced any new symptoms or have previous symptoms worsened?
- Do you have a lingering or new fever?
- Did you receive a discharge summary and have you read it?
- Do you have questions about your medications?
- Do you have an appointment with your primary care physician for follow up?
- Do you know how to contact your primary care physician or the hospitalist who treated you during your stay?
- Has this call helped you feel better about your treatment?

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