Post-Discharge Follow-Up Calls

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Introduction

One of the six new quality measures implemented by the Centers for Medicare and Medicaid Services (CMS) is the percentage of short-term stay patients that are successfully discharged to the community. CMS defines successful discharge as residents discharged from the nursing home to the community within 100 calendar days of admission from the hospital and for 30 subsequent days, they did not die, were not readmitted to the hospital for an unplanned inpatient stay, and were not readmitted to a nursing home. This measure was first reported by CMS in April of 2016, and integrated inot the Five-Star Quality Rating System in July 2016. Since the measure was integrated, Dove Healthcare – Wissota Health and Regional Vent Center had not modified their discharge process to ensure the successful discharge of the patients discharged from the facility to the community.

Knowledge of Task

Project Re-Engineered Discharge (RED) was created by the Agency for Healthcare Research and Quality (AHRQ) to train hospitals and discharge planners on a post-discharge follow-up call. Project RED is designed to have any hospital personnel call patients 48-72 hours after discharge to ask about the patient's condition, including compliance and understanding of medication and treatment orders. The caller should also ask about the patient's understanding of their condition and intent to follow through with follow-up appointments. The caller is to use a generated call script and know when a second call by a nurse, pharmacist, or physician is warranted. To ensure patient safety and achieve high rates of successful discharge for the new Quality Measure, Project RED can be brought to the skilled nursing setting.

The goal of the follow-up program is to ensure patient safety and well-being and to achieve high rates of successful discharge. This indicates that the facility is restoring patient's function so they may successfully return to the community. It is the goal of Dove Healthcare – Wissota Health & Regional Vent Center that discharged patients remain in the community and avoid rehospitalizations and readmissions to the facility.

Methodology

Several email groups were modified and created to implement the post-discharge follow-up call process. The call script was created to include:

- If the patient was able to get their prescriptions filled
- If they have any questions about their medications
- If they know the date of their follow-up appointment and if they will have trouble getting there
- If home health visits have been going well
- If they have all the equipment they need
- If they are following their exercise program
- If they have any concerns

Step One

- Social Worker communicates patient's discharge plan to the designated e-mail group.
- Date and time of discharge, destination, in-home services to be provided, and meal assistance to be provided are included in the discharge plan communication.

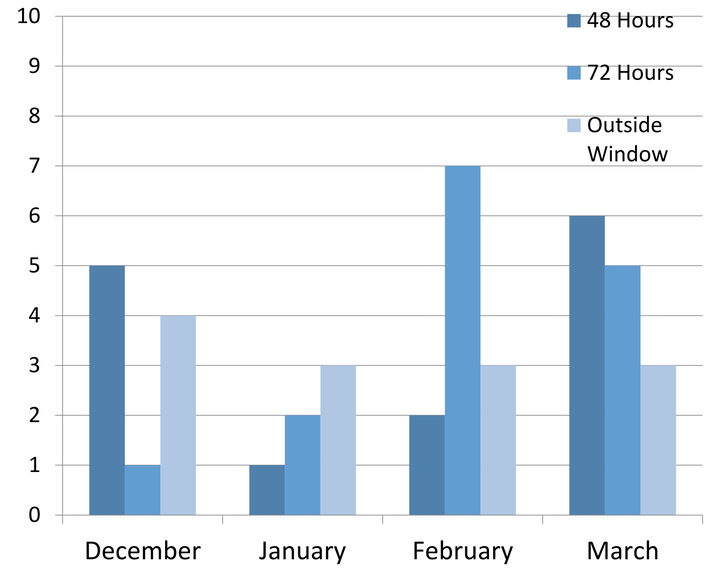
Step Two

- Within 48-72 hours of discharge, the Administrative Assistant calls the discharged patient.
- The Administrative Assistant records the conversation on a printed copy of the phone script

Step Three

- The Administrative Assistant scans the phone script to the designated e-mail group. She makes note of any concerns or issues that should be followed-up on.
- The follow-up phone call is made by the necessary party, and recorded on a resident concern form.

Chart 1. Follow-Up Call Timeliness



Results

Since the first post-discharge follow-up call was made on December 12th, the facility has had:

- 41 patient discharges to the community
- 38 follow-up calls made
- 5 phone calls requiring a secondary follow-up call from the rehabilitation nurse manager
- 1 patient was readmitted to the facility despite a follow-up call and secondary follow-up call
- 4/5 secondary follow-up calls were needed due to questions or concerns with medications
  - One patient was not able to pick up their medications as planned, and could not find someone to help
  - One patient claimed their medications were causing them to feel tired and groggy
  - One patient did not receive enough Omeprazole after some confusion with bubble packs between the facility and the patient's pharmacy
  - One patient had questions regarding an antibiotic and a stool softener
- The other patient had complaints of weakness at home, and despite facility efforts, he was readmitted

Table 1. Post-Discharge Follow-Up Call Data

	Discharges to Community	Follow-up Calls Made	Unplanned Readmissions to Facility
December	10	10	0
January	7	6	0
February	14	12	1
March	14	14	0

Conclusions

The project was successful at identifying issues after the patient had returned home to ensure successful discharge. The Administrative Assistant was able to identify areas of concern and report them to the post-discharge team. The nurse manager and social worker were able to complete secondary calls to the discharged resident for follow-up.

The communication within the post-discharge team was excellent. The Administrative Assistant was able to point out areas that needed attention so the appropriate person was able to quickly follow-up. The nurse manager and social worker communicated a summary of the follow-up back to the group to ensure follow-up was completed and interventions were implemented. Though not all calls were made within the 48-72 hour window, no calls completed outside of the window or missed calls resulted in a negative patient outcome.

The system worked well for Dove Healthcare – Wissota Health & Regional Vent Center, but there were issues with contacting patients that were discharged to assisted living facilities. Staff members were unable to reach them after discharge.

Recommendations

Moving forward, it is recommended that the follow-up phone calls be made by the Unit Nurse Manager. The Nurse Manager would have the ability and knowledge to complete deeper assessments on patients with high risk conditions such as Congestive Heart Failure and Chronic Obstructive Pulmonary Disease.

It is also recommended that the facility calculate the risk for the patient to be readmitted to the hospital upon admission to the facility. With this calculation, the facility would be able to better assess the needs of the resident during and after the patient's stay to ensure successful discharge to the community or the least restrictive setting.

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