EXPERIENCE EXCHANGE

Post-visit phone calls: Reducing preventable readmissions and improving the patient experience

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Abstract

Post-visit phone calls reinforce discharge instructions, improve clinical outcomes (by extending care outside the walls of the hospital), and address the new urgency of preventable readmissions due to at-risk hospital reimbursement under the Affordable Care Act. And yet, new data released by the Centers for Medicare & Medicaid Services show stagnant performance on preventable hospital readmissions nationwide for heart attacks, heart failure, and pneumonia. This article offers guidelines for effective post-visit phone calls, describing how and when to make calls and suggesting recommended questions for post-visit calls. Appropriate goals for contact rates in various clinical settings, methods for ensuring staff compliance, and best practices to improve the patient experience and reduce preventable readmissions are identified.

Key words

Post-visit phone calls, Discharge phone calls, Preventable readmissions, Patient experience

1 Introduction

Post-visit calls reinforce discharge instructions, improve clinical outcomes, reduce patient anxiety and complaints, reinforce positive patient perception of care, and reduce preventable readmissions. They also provide opportunity for quick service recovery.

While physicians and nurses feel more confident when they know their patients understand and are accurately executing their discharge instructions, evidence demonstrates this is frequently not the case. One study found that 81% of patients requiring assistance with basic functional needs failed to receive a home care referral, and 65 percent said no one at the hospital talked to them about managing their care at home [1]. A 2012 study published in the *Annals of Internal Medicine* [2] found that patients were frequently taking medications too long, missing doses, or taking the wrong dose. Twenty-three percent of these errors were found to be serious and 1.8% were life-threatening. Furthermore, Joint Commission has noted that 19.6% of Medicare patients are readmitted within 30 days; 90% of readmissions are deemed unplanned; only 50 % of those readmitted had seen their physician prior to readmission; and these readmissions were estimated at $17.4 billion for one year (2004) [3].

Recently, reducing preventable readmissions has taken on new urgency. On October 1, 2012 the Centers for Medicare & Medicaid Services (CMS) implemented the Preventable Readmissions Program. Approved by the Affordable Care Act as part of healthcare reform, the Preventable Readmissions Program aims to reduce the estimated $1.7 billion spent annually on readmissions. It will accomplish this goal through the assignment of a one percent reimbursement penalty to those prospectively paid hospitals determined to have excess admissions. Medicare officials have projected that the 1 percent penalty is expected to total over $960 million across approximately 3,500 hospitals potentially impacted [4].

According to a 2011 article in the *American Journal of Managed Care*, recent estimates suggest that almost one-fifth of Medicare beneficiaries discharged from a hospital are readmitted within 30 days [5]. In short, it has never been more critical to implement consistent post-visit phone calls to patients in inpatient, emergency department, behavioral health, medical practice, and other healthcare settings.

In our experience working with healthcare organizations to achieve and sustain clinical and operational outcomes, there is a direct correlation between effective post-visit phone calls and reducing preventable readmissions. At Cheyenne Regional Medical Center in Cheyenne, WY, for example, where the average cost per Medicare readmission is $9,923, the team reduced acute care admits within 30 days of acute care discharge 42% to just 7.85% of patients between October 2011 and July 2012 through the use of post-visit phone calls (see Figure 1).

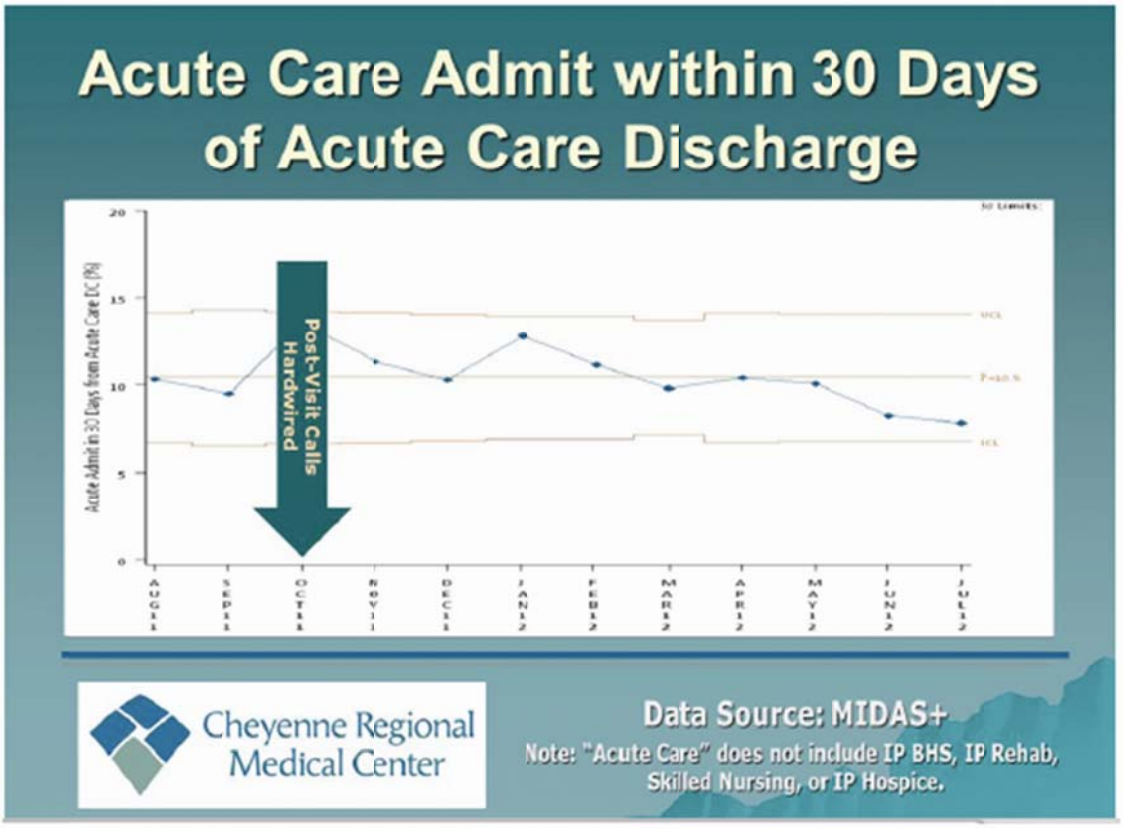

Figure 1. Cheyenne Regional Medical Center reduced acute care admits within 30 days of acute care discharge by 42% by hardwiring post-visit phone calls

Body copy: The goal in seeking to reduce preventable readmissions isn't to discharge the patient, but rather to rethink the plan of care to include phases, such as an inpatient and a transitioned home care plan. In a recent "think tank" forum of nursing and non-nursing leaders, there was clear consensus that ultimately hospitals will become chronic disease managers, and care will become increasingly longitudinal—especially in the first 30 days post-discharge.

2 Guidelines for effective post-visit calls

It is recommended that hospitals aim for *always* with respect to making post-visit phone calls, attempting to call 100 percent of patients discharged home. Consistency of calls and high contact rates are most effective to reduce preventable readmissions and ensure safety, quality, and service for quality clinical outcomes. While many hospitals make post-visit phone calls, they make them *sometimes* versus *always* so they are ineffective. Not all patients will be reachable, but speaking with 70% to 80% of patients is acceptable. However, even contacting a minimum of 50% of eligible patients will improve results [6].

The most effective way to implement post-visit calls is via a centralized system in which all data feed to one collection point. This allows hospitals to maintain accountability for those assigned to make calls. A central system also helps organizations benchmark results and determine which departments are performing best with calls and contact rates to identify and replicate best practices.

2.1 How and when to make the calls

The list of patients to be called can be compiled electronically using electronic medical records or an electronic registration system. Otherwise, a copy of each patient's discharge instructions and face sheet are stapled together and can serve as call inventory. This list is then "scrubbed" for certain types of patients not typically contacted. Staff does not call fatalities, transfers, and certain psychiatric diagnoses. Obstetric unit staff might not make contact in the case of a fetal demise. In the emergency department, staff may choose not to call sexual abuse patients. In such cases, contact may come from different resources. Each unit needs to carefully consider which patients to call. Leaders must ensure the right balance exists between appropriate and scrubbed calls.

To maximize clinical outcomes, post-visit calls should be made by the unit's nursing staff, which shares the responsibility for calling patients discharged the previous day. It is valuable for staff nurses to hear how patients perceive their care. Calls take place within a 24 to 72 hour time frame after discharge (or until the nurse has made three contact attempts). This time period for calls is critical to effectiveness in reducing adverse events. In fact, 90 percent of adverse events will occur within the first 72 hours of discharge [7].

If staff resources prohibit calling by nurses closest to the patient, consider the use of non-traditional resources such as light duty or retired nurses. If non-licensed staff are used to make post-visit phone calls, it is important to provide training and to ensure there is a process where they can refer patients to a nurse or physician in cases where clinical issues or medical questions arise. Post-visit calls should take three to five minutes each.

The night shift can prepare the list of eligible patients for the day shift to call each morning. The calls are then distributed evenly by the dayshift charge nurse among all staff nurses and physicians who must complete their assigned calls during their shift. Calls are typically made between 8 am and 8 pm, with a recommended "call blitz" between and 5 and 8 pm for those patients for whom messages have been left.

2.2 Recommended questions

To encourage nurse engagement in post-visit phone calls, it is recommended that nurse leaders work collaboratively with staff nurses to determine priority questions to ask patients. Begin by reviewing patient perception of care survey results to identify key opportunities to improve patient perception of care metrics.

It is important to emphasize to staff nurses that the purpose or the "why" of the post-visit phone calls is to drive clinical outcomes and process improvements to improve the standard of care with actionable feedback. Post-visit calls are not "mini-patient satisfaction surveys". As the most important questions to ask patients are identified, focus discussion among nurses around some of the following questions:

- What do you worry about when you discharge patients home (e.g., understanding discharge instructions, pain controlled, follow-up appointment made)?
- What do you want patients to teach you with regards to your care (e.g., verification of hand hygiene; kept patient and family informed of plan of care)?
- What aspects of service or quality do you want feedback on (e.g., received very good or excellent care; armbands checked before medication administered; procedures explained in a way patient understood)?
- Who provided the patient with memorable care? (This provides opportunity to recognize nurses, physicians, and other caregivers. Recognizing and rewarding high performers is an essential component of creating and sustaining an organizational culture of high engagement and high performance.) [8]

It is also important to ask questions to elicit maximum information. Avoid yes/no questions in favor of using a scale (e.g., always, usually, sometimes, never) or several choices for patient response. Use structured questions to ensure call efficiency and accurate feedback over open-ended questions.

A series of four to six well-constructed questions will provide timely, actionable feedback. Using a solid script with key words to guide callers fosters consistency and assures each nurse touches on priority items identified by the team.

Note: The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey impacts post-visit calls. It is imperative that nurses making post-visit phone calls be sensitive to the survey guidelines as developed by CMS. Healthcare organizations may under no circumstances use any HCAHPS questions within the context or script of post-visit phone calls. Callers must also avoid asking questions in such a way that would encourage a specific type of response to the HCAHPS survey by patients receiving post-visit phone calls. To learn more about the HCAHPS survey, nurse leaders should speak with their organization's quality department director or visit the HCAHPS website at www.hcahpsonline.org and review the *HCAHPS Quality Assurance Guidelines V 8.0* found under the Quality Assurance navigation button.

2.3 Setting goals for post-visit calls

The attempted goal, as noted earlier, is always to contact 100 percent of eligible patients. Minimum contact rates are recommended as follows: emergency department - 60%; inpatient - 70%; and ambulatory surgery/outpatient – 80%. These contact rates take into consideration the challenges with incorrect phone numbers [9].

When collecting data, attempts are counted by number of patients actually called, rather than the number of times nurses attempted to call each patient. For example, if the goal is to contact ten patients, but nurses attempted to call eight patients—even if dialing the number twice for each one—the number of attempts are logged as eight, rather than sixteen.

Because documentation is critical to the success of post-visit calls, they must *always* be documented. A standardized paper or electronic format question template that documents patient responses at the time of the call may be used. If using a manual system, staff place completed post-visit phone call logs in a central place at the nurse's station. The manager or charge nurse then reviews these to identify trends and opportunities and notes information that has been captured in a central spreadsheet. In addition, the manager collects and reviews logs each day. The goal: to cascade the sharing of wins and opportunities to improve with staff nurses and physicians. It is recommended that information is cascaded widely to ensure full transparency and opportunity for quick course corrections. Leaders can share findings in daily huddles, stand-up meetings, and weekly management team meetings.

2.4 Getting started

Best practice is for the nurse leader to begin making calls at the nurses' station or another location where staff nurses can observe. This reduces anxiety as nurses see that the calls are quick and easy to make. Next, several high-performing nurses

are asked to make calls and share stories of clinical "wins". It only takes one clinical save for reluctant nurses to become consistent believers in post-visit calls [9].

After several weeks of calls initiated by nurse leaders and high-performing nurses, they can be transitioned to the rest of the staff. Remember: The process of creating and sharing wins is essential to sustaining momentum for consistently making patient calls. The feedback staff receives and stories shared ensure staff understand that post-visit calls are a valuable tool in extending care beyond the walls of the hospital to build a continuum of care for the patient and an opportunity for service recovery. Staff also feel appreciated for the care they have provided, resulting in a positive cycle of higher employee engagement. For post-visit calls, seeing truly is believing.

2.5 Ensuring staff compliance

The reasons for making post-visit phone calls must be "over-communicated" to ensure staff compliance. Explain that post-visit phone calls are an evidence-based practice to ensure patients are complying with medication and discharge instructions. The calls reduce patient anxiety, reinforce patient perception of care, and improve clinical outcomes by ensuring the organization has a process in place to intervene clinically should they need to do so. They also validate the quality of care delivered for continuous process improvement.

After the calls, "wins" are shared widely and consistently so that staff experience the positive outcomes (e.g., clinical saves, catching medication errors, expressed appreciation by patients and family). It is useful to segment the data to show staff monthly the difference in patient perception of care between patients who received calls and those who did not. While it is common for busy nurses to express reluctance about having time to make the calls—or view it as one more task to be completed—they are quickly converted to believers once they make the first clinical save on a call.

It is highly recommended that organizations implement Rounding for Outcomes by leaders on staff prior to beginning post-visit phone calls to patients. Rounding is designed to address staff needs and concerns, ensure staff have the tools and equipment to do their jobs, improve processes, build relationships, and reward and recognize high performers. If post-visit phone calls are implemented prior to leaders rounding on staff, staff are likely to hear more patient complaints than compliments, which will likely reduce staff compliance with making the calls, and undermine momentum for consistency and results in improved safety, patient perception of care, and preventable readmissions [10].

2.6 Skills validation for training

In some instances, nurse leaders find that even though they have trained staff on how to make post-visit phone calls, the organization is not seeing hoped-for results. It is recommended that "skills labs" are used to validate and verify that post-visit calls are "hardwired" (defined as being executed consistently and accurately 90 percent of the time) to ensure caregivers are providing highly reliable care.

Skills labs are "gap finders". They are teaching and coaching opportunities provided after training has been completed. They identify gaps between what nurses believe they are doing and what they are actually doing. Essentially, nurse leaders are recruited as actors to serve as patients and evaluators while nurses make post-visit phone calls to them. Consider conducting skills labs with several nurses at once so the group may benefit from extra learning as individuals receive feedback [11].

When conducting skills labs to validate training on effective post-visit phone calls, the use of a competency checklist is highly recommended. The checklist documents both the nurses' self-assessment and that of the evaluator with respect to key questions for post-visit phone calls.

2.7 Tips and best practices

The following tips and best practices are recommended to further accelerate results with respect to improving the patient experience and reducing preventable readmissions through the use of post-visit phone calls:

- Inform patients at discharge that a nurse will be calling to follow up and answer any questions within 24 to 48 hours. Also, verify "best number" and time to call with the patient to increase contact rates.
- Use serial callbacks. It is recommended that calls for patients at high-risk of readmission be repeated at specified intervals. For example, congestive heart failure patients should be surveyed within 48 hours post-discharge, with additional post-visit calls at 7, 14, 21, and 28 days post-admission. (Greenville Memorial Hospital in Greenville, SC credits the hardwiring of serial post-visit phone calls to CHF patients as an important aspect of its ability to reduce its 30 day All Cause Readmission Rate to 18.5%, the second lowest overall CMS 30-day readmission rate for heart failure nationwide and well below the CMS reported 24.8% national average (2007-2010).
- Ask diagnosis-specific questions. For example, patients admitted for acute myocardial infarction (AMI) who have had a cardiac catheterization can be asked, "How does your procedure site feel/look?" "Any bleeding where your catheter was inserted?" Stroke patients can be asked Coumadin-related questions and "Can you tell me the signs and symptoms of a stroke?"
- Automate the post-visit phone call process. Many organizations use software to automate the post-visit call process to standardize questions, provide a centralized repository for recording patient feedback, and generate reports on data gathered (e.g. based on type of patient, callers, and/or unit/leader metrics.) Questions analysis displays counts and percentages of various responses to survey questions, based on multiple selection criteria.

3 Summary/Conclusion

Post-visit phone calls to discharged patients have been demonstrated to achieve measurable improvement in both the patient experience and reduction of preventable readmissions. To achieve results, calls must be executed consistently with a high percentage of actual patient contacts with documented results for feedback to callers. Questions must be standardized for all callers, but focused for special patient populations. Skills labs are highly recommended as a method to identify gaps in training and to validate the post-visit calls are hardwired.

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