Discharge Follow-Up Phone Calls:

The Ultimate Tool for Excellence in Transitions of Care, Patient Experience and Readmission Prevention

AnMed Health

Program Review

- Initiated November 2018, in partnership with Cipher Health
- Patients discharged to home from Inpatient or Observation status, receive an automated follow-up call within 24 hours of discharge
  - Automated call system allow for efficient mass outreach and consistency with scripting, and issue identification
  - Calls cover key elements for transitions of care from the hospital to home including general status, medication access, medication questions, follow-up appointments, and contact with home care and DME services.
- Call programs:
  - General Inpatient
  - Cardiac: includes diagnosis of heart failure, acute myocardial infarction, coronary artery disease, or CABG/TAVR, and is composed of 4 calls over a period of 4 weeks with disease specific questions
  - Pneumonia: includes patient's with primary diagnosis of pneumonia and is composed of 4 calls over 4 weeks with disease specific questions
  - COVID-19 specific calls initiated April 2020. Patients with a primary diagnosis of COVID-19 receive 1 automated call and 4 manual calls over a period of 2 weeks to address symptom management, and to ensure social determinants of health are addressed during their home quarantine periods.
  - 4th Manual Call: those patients that do not answer the General Inpatient call receive a manual call attempt from the Call Team, increasing call reach rates
- Discharge call issues for all call programs are addressed by a team of Nurse Case Managers. This robust discharge follow-up call program has contributed to a decrease in readmissions, increase in participation in Press Ganey surveys with improved scores in areas related to discharge and transitions of care, and increased completion of Transitions of Care (TOC) appointments with primary care physicians.

Outcomes

- In both the 2019 and 2020 Program Readmission Reviews, a significant decrease in the readmission rate was noted for those patients who answer the automated call as compared to those who did not, as well as a decrease in readmission rate for those patients with issues who spoke to an RN on the Call Team versus those patients who noted having an issue but did not answer the Call Team's outreach attempt. 2021 Readmission Review is in progress.
- In the first year of implementation, an increase in completion of Press Ganey surveys was noted, as well has higher patient satisfaction scores in discharge and transitions of care related questions.
- Compliance in completions of Transition of Care (TOC) visits increased.

Learning/Next Steps

- Monthly unit based reports identify top patient issues, so that each unit has an opportunity to address their areas' challenges and needs. The **top 3** system **opportunities** identified by the discharge follow-up calls are scheduling of **Transitions of Care appointments** prior to discharge, general status (symptom/**disease management and education**), and **medication access** or medication questions.
- The disease specific calls have shown the greatest impact on readmission rates. The addition of a COPD specific call is being included in "next-steps" for our discharge follow-up program and is expected to go-live by May 2022. By year end, each discharge call program will be outfitted with a text survey option, in order to increase reach rate and patient participation. ED specific outreach calls have also been identified as an opportunity to ensure closure in care gaps for those patients discharge directly from the ED, as well as a chance to address an service recovery needs.