sentara nurse

Leveraging Technology Post-Transition to Prevent Readmissions

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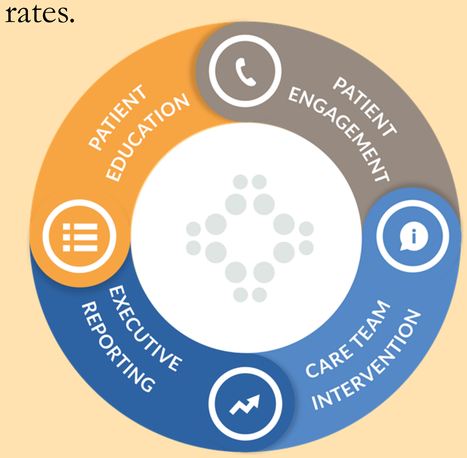
Introduction

Monitoring patients' progress following hospital discharge is a key strategy to promote successful recovery and prevent readmission. This innovative patient outreach program successfully engages patients following discharge, tracks their progress, and escalates issues back to clinicians for prompt resolution.

Problem

Traditional discharge phone calls often lack standardization and a manual calling process can be challenging to sustain. An automated, technology-based calling program with diagnosis-specific call scripts and a customized escalation process improves patient reach rates and reduces 30-day readmission rates.



Used with Permission from: CipherHealth Voice Best Practices

Purpose

Goals of the program:

- Engage patients following discharge to answer any questions and address concerns.
- Facilitate successful transition from hospital to home.
- Prevent hospital readmission.

Measure

The measure used to evaluate improvement was the 30-day inpatient readmission rate for patients who were reached by the automated calling program compared to those who were not reached. Redundant methods were used to optimize the reach rate.

Implementation

Program Best Practices

- **Timely Initial Outreach**: Deploy the first call within 48 hours of discharge to ensure patient needs are met.
- **Efficient Model for Call Backs**: Create a system that enables the team to call patients back and resolve issues within 24 hours.
  - SWRMC employs a centralized workflow to optimize program efficiency.
- **Make Four Call Attempts**: Multiple attempts to contact the patient improves reach rate and reduces likelihood of readmission.
- **Utilize Best-Practice Scripts**: Helps ensure reporting and patient engagement is optimized.
  - SWRMC uses General Inpatient, Heart Failure, Pneumonia, Sepsis, COPD, and Acute Myocardial Infarction scripts.
- **Clinicians Perform Call Backs**: Issues identified during the automated call are escalated to clinicians who promptly call the patient to answer questions and resolve concerns.
- **Tiered Escalation Process**: SWRMC employs a three-tier escalation process:

Strategies for Driving Improvement

- **Collaborate effectively**: Work across teams to share metrics, identify areas for improvement, and trend escalations.
- **Resolve issues promptly** to enable a successful transition and prevent readmission.
- **Act upon the data**: Proactively review monthly reports to identify opportunities and address recurrent issues.
- **Educate patients** to improve the overall Reach Rate.


Patient Partnership

What You Need To Know About Your Follow-Up Phone Call

OUR TRANSITION FOLLOW-UP OVER THE PHONE
Our concern about your health does not end when you leave the hospital! You may receive an automated call in order to gather important information about your health status.

HOW IT WORKS
You may receive a phone call from our **automated** system to ask you a few important questions about your health and progress. Your answers will be reviewed by a Sentara clinician.

How You Participate

You may get an **automated call** within 48 hours of leaving the hospital.

The automated call will ask you clinical questions. Please answer the questions using the phone keypad.

Based on your answers, a clinician from Sentara may call you to offer help and instructions.

Because of the importance of this call, the system will contact you a second time if you become disconnected.

"We care about your well-being and partnering in your care. Thank you for choosing Sentara Healthcare!"

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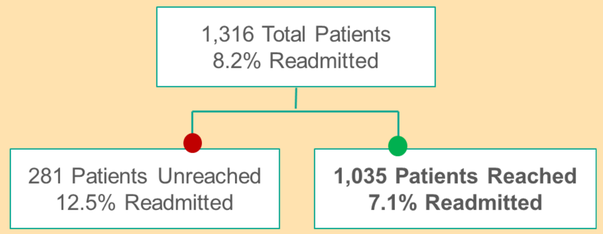
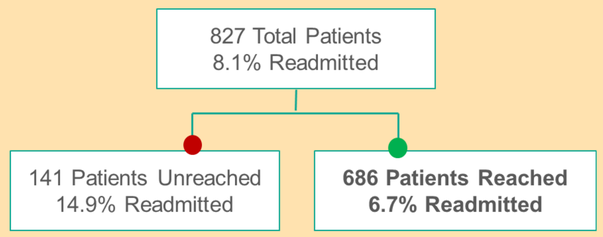
Evaluation

The targeted outcome measure was readmission rates (RR) for patients reached compared to those not reached by the automated calling program. For qualifying patients discharged from SWRMC throughout the 3rd and 4th quarters 2016, the RR was significantly lower for patients who were called and reached (7.1%) versus those who were not reached (12.5%):



$p = 0.0034$

A similar difference in readmission rate between reached and unreached patients continued throughout the 1st quarter 2018:



$p = 0.0012$

Implications

Nursing implications include opportunities to promote care coordination and enhance the transition process based on aggregate data and reports generated from the calling program. Identification of strategies to increase patient participation in the automated calls is critical to program success.

Conclusion

Patient safety is a top priority at Sentara. This technology-based, innovative solution to engage patients post-transition helps close the loop on safety concerns, provides reassurance to patients during a vulnerable period, and facilitates identification of areas for future improvement.

Contact Information

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