Making Post-Discharge Calls Work for Your Patients and Your Nursing Staff

The debate is not whether post-discharge calls play an important role in patient care; we already know they do. In one study of 400 consecutively discharged patients, 19 percent reported adverse events (i.e. drug events and procedure-related injuries) post-discharge. Forty-eight percent of these were preventable (Forster, Murff, Peterson, et al, 2003). The real questions are: who will make the calls; and how do we optimize the calls to have a positive impact on the patient experience and the hospital’s bottom line?

According to a 2011 AONE Voice article, Leveraging Technology for the Future of Nursing Care Delivery, most hospital leaders support the need for innovation in order to equip direct care nurses with the tools they need to multitask in their complex work environment. In fact, research shows that nurses in acute care environments typically complete 100 tasks per shift with interruptions every three minutes (Tucker, 2006; McGillis, et al, 2010). This is not exactly something you want to include in your recruitment efforts to attract and retain top nursing talent. It’s also not a statistic that would compel anyone to add another task to the plates of hospital nurses.

However, the realities of the current health care delivery system may result in some cognitive dissonance, as we position ourselves to succeed under the new accountable care framework. Reducing readmissions is non-negotiable. So is reaching the highest percentile for the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. But taking care of patients will remain the number one priority for nurses and for hospitals. How can nurses continue to care for patients at the bedside and support these new patient care goals? Unless you bring the right data and an alternative solution to your executive leadership, post-discharge services are likely to become nothing more than another task for your nursing staff.

Optimizing post-discharge calls

All post-discharge calls are not created equal. It’s important to remember that post-discharge calls are made to sick or recovering patients—not to people who are performing at the top of their game. Sometimes these calls involve talking to a family member or another caregiver, which is not a substitute but a conduit to understanding the patient’s status and needs. The bottom line is that these calls require time, focused attention and often multiple attempts to reach a patient and/or caregiver to resolve any issues they may have. While hospitals understand the importance of post-discharge calls, few have considered the goal and best resource to make these calls and the appropriate infrastructure for documentation.

What’s the goal?

Hospitals must first determine the reason for making these calls. Is it a patient satisfaction call, designed to tell patients that the hospital really cares about them and their recovery with the goal of building patient loyalty? Or, is it a clinical call, designed to ensure that patients are progressing in their recovery, understand their discharge instructions and have everything they need? Is the goal to identify and address real-time service recovery issues? Or is it all of the above? All are laudable goals, but defining your goal is key to identifying the most appropriate resources for achieving them.

Who or what is the best resource?

After establishing the goal, hospitals can determine the most appropriate resource for making these calls. There are three basic models: an in-house contact center, the nursing staff on the floor and an outsourcing partner.

• In-house contact center—Whether it is articulated or not, hospitals that have their own in-house contact center are generally interested in providing patient satisfaction calls to build patient loyalty and/or identify service delivery issues. Documentation of these calls and escalation of issues is generally a manual process, supported by some type of customer relationship management (CRM) software in conjunction with phone and email correspondence. In some cases, contact center staff members are well trained and integrated with the service excellence team. These calls are generally limited to daytime hours and to a subset of patients, since most in-house contact centers do not have the capacity to call all discharged patients. Finally, if hospitals are interested in tracking whether these calls impact future behavior, they need to manually link the call database to the clinical database to determine whether there is any correlation between post-discharge calls and patients choosing the hospital or health system for their next health-related need.

• Nursing staff—Hospitals that rely on floor nursing staff to make post-discharge calls are focused on optimizing outcomes and reducing readmissions. Documentation of these calls tends to be manual–either on paper or in a spreadsheet. Additionally, nurses often do not have access to physician information to assist patients with referrals or scheduling of post-discharge appointments. And while nursing schedules extend beyond a traditional administrative day shift, nurses have other competing tasks that trump documentation of post-discharge calls. The bottom line is that post-discharge calls are often marginalized under this model because nurses do not have the time or the supporting infrastructure to aid documentation.

• Outsourcing partner—Outsourcing this aspect of the patient experience allows hospitals to choose whether they would like to focus on patient satisfaction, service recovery, clinical care or all of these issues. Which option they choose is often driven by the price tag, but scalability and flexibility are inherent in the outsourcing option.
A strong outsourcing partner will have the technological infrastructure to provide proper documentation of phone calls, as well as analysis of the information to hospitals. Additionally, patient advocates should be able to close the loop for your patients by scheduling any post-discharge appointments with physicians or by connecting the patient with a primary care physician, if one does not exist. Finally, an outsourcing partner should be able to make timely patient calls (within 48 to 72 hours of discharge) and be reachable 24 hours a day, seven days a week.

**Optimizing the patient experience**

With post-discharge calls, hospitals have the opportunity to improve both their HCAHPS scores and percentile ranking. One community hospital in the western United States instituted post-discharge calls and improved their composite percentile ranking by 12 points, from 72 without calls to 87 with calls (BerylHealth, 2011). Post-discharge calls had significant positive impact on two specific nurse-related questions as well:

- “Nurses listened carefully to you” improved from the 55th percentile without calls to the 94th percentile with calls.
- “Nurses explained things understandably” improved from the 63rd percentile without calls to the 91st percentile with calls.

**Decreased readmission rates**

With post-discharge calls, hospitals have the opportunity to reduce their readmission rates by identifying and resolving issues in a timely manner. At a 250-bed community hospital in the Southwest, data was collected over an 18-month period of time. The 30-day readmission rate for patients that received a post-discharge call was 7.99 percent, compared to a rate nearly double, 14.32 percent, for those patients who did not receive a follow-up call. Since 30-day readmissions accounted for nearly 8,000 patients, post-discharge services decreased readmissions by 506 patients (BerylHealth, 2011). At an average cost of $12,000 per patient, the estimated savings was over $6 million (Williams, Miller, Maynard, et al, 2011).

Since readmissions tend to be 30 percent to 40 percent more costly than initial admissions, and since readmission rates are now tied to Medicare reimbursement, there is also a significant cost savings and bottom line protection associated with reduced readmissions (Niu, Hochstadt, 2009). In a 410-bed medical center in the Northeast, data was collected over a 20-month period for patients across multiple units. The 30-day readmission rate for those who received post-discharge calls was 10.78 percent, compared to nearly 16 percent for patients who did not receive a follow-up call. Since 30-day readmissions accounted for 3,500 patients, post-discharge services decreased readmissions by 174 patients. And at an average cost of $12,000 per patient, the estimated savings was greater than $2 million (BerylHealth, 2011).

In addition to helping your executive team understand the limitations and benefits of the prevailing models of post-discharge services, there are some other important considerations:

- The average mid-sized community hospital with 100,000 patient encounters (i.e. inpatient, ED and outpatient) that uses its in-house nurses to conduct post-discharge calls needs more than four full-time nursing equivalents (RN FTEs) to complete the tasks (Williard, Baird, 2011).
- An estimated 5 percent of post-discharge calls require escalation back to the floor nursing team (Williard, Baird, 2011). If hospitals partnered for the other 95 percent of calls, the impact on the nursing model would require 0.25 RN FTEs to complete calls—a more efficient and effective model for meeting patient needs and minimizing the negative impact to bedside nurses.

Today, post-discharge calls are a must-have for providing quality patient care. But it’s important to keep in mind that for a clinical follow-up, a registered nurse is the most appropriate person to make the call. And when that nurse is an extension of the hospital-based care team—which allows your nurses to focus on the patients in their immediate care—everyone wins.

**References**


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