Post-discharge calls help improve care coordination, reduce readmissions

MASSACHUSETTS GENERAL HOSPITAL

Massachusetts General Hospital (MGH) emergency department (ED) is a busy Level 1 Trauma Center located in downtown Boston that sees over 100,000 patient visits each year.

Challenge

When data indicated that fewer than half of patients followed up with their providers after a visit to the hospital, emergency department staff at MGH, which records 100,000 visits annually, developed a nurse-led, volunteer administered patient call-back system to increase post-discharge compliance with provider follow-up and reduce readmissions.

Initially, ED staff reviewed post-discharge instructions with patients in person and again through a call 24-48 hours later reminding them to follow up with their specialty or primary care provider. Although patients indicated that they understood their care instructions, over the years, staff realized that patients when probed couldn't describe the instructions they received. In addition, very few realized the importance of connecting with their PCP to avoid another readmission.

Action

With this information in mind, the ED team used a Plan-Do-Study-Act methodology to develop the Emergency Department Discharge Call Program. MGH uses a Studer Group patient call management system. The system downloads from Epic, MGH's EHR software, the names of patients discharged the day before. On average, post-discharge nurses perform 100 call attempts a day. A patient may get 2-3 calls in an attempt to reach them. On average, nurses reach 50 percent of the patients they call.

Post discharge nurses now ask patients 'what are your discharge instructions'. From there, post-discharge nurses can clarify next steps as well as connect patients to the resources they need to comply with those instructions, whether that be to get in touch with outpatient providers, assist in obtaining medications, and accessing social services. Post-discharge nurses will even go visit the outpatient office if it's located on the hospital campus. These nurses still work on the ED floor so they are still tuned into how things work in the clinical space. They are given permission by the nursing director almost every day to do the post-discharge calls but are sometimes pulled back into the ED on very busy days.

Recently, the post-discharge call program added a second reminder call by volunteers. After careful consideration of liability and privacy concerns, the team recruited HIPAA-certified hospital volunteers to make a second reminder phone call 72-96 hours after discharge. Nurses manage the volunteers and address any clinical issues. The program is now considering having volunteers do a third call-back reminder call to follow up with their provider in an effort to reach as many patients as possible. No medical advice is provided by the volunteers.

Outcomes

With a large population of elderly patients living alone, staff feel that personal calls are more appropriate rather than a text-based system. Patients appreciate the human-focused approach, as well as the nurses and volunteers who help with overcoming barriers in scheduling follow up visits.

With this three-tier approach, patient compliance with contacting their PCP within seven days post discharge increased from 48 to 63 percent. This clinical process improvement resulted in increased patient satisfaction and improved coordination of care, both of which decrease preventable ED readmissions.

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